HEALTH AND WELLBEING BOARD

Venue: **Town Hall, Moorgate Street, Rotherham S60 2RB**

Date: **Wednesday, 18th January, 2012**

Time: **1.00 p.m.**

A G E N D A

1. To determine if the following matters are to be considered under the categories suggested in accordance with the Local Government Act 1972.

2. To determine any item which the Chairman is of the opinion should be considered as a matter of urgency.

3. Minutes of Previous Meeting (Pages 1 - 9)

4. Drinking Alcohol in Rotherham (Pages 10 - 15)

(The Chairman authorised consideration of the following 2 items to enable the Board to be fully informed.)

5. Rotherham Cold Weather Plan (Pages 16 - 49)

6. PIP Breast Implants

7. Children and Young People's Plan 2010-13 Progress Report (Pages 50 - 56)

8. NHS Operating Framework (Pages 57 - 68)

9. NHS National Outcomes
   - please follow the link
   http://www.dh.gov.uk/health/2011/12/nhs-outcomes-framework-renewed-focus-on-improving-patient-results/

10. Health and Wellbeing Board Work Programme and Support and Development Plan (Pages 69 - 81)

11. Early Implementer National Learning Sets (Pages 82 - 84)

12. Appointment to Health and Wellbeing Board
- consideration of request from Chamber of Commerce to become a member of the Board

13. Date of Next Meeting
- Wednesday, 29th February, 2012, at 1.00 p.m.

HEALTH AND WELLBEING BOARD
Wednesday, 7th December, 2011

Present:-

Councillor Wyatt	**In the Chair**
Christine Boswell	RDaSH
Brian Chapple	Rotherham United Football Club
Tom Cray	Strategic Director, Neighbourhoods and Adult Services
Paul Douglas	Rotherham United Football Club
Councillor Doyle	Cabinet Member for Adult Social Care
Chris Edwards	NSHR/RCCG
Kate Green	Scrutiny and Policy Officer, RMBC
Matt Gladstone	Director, Commissioning, Policy and Partnerships
Tracy Holmes	Communications, RMBC
Brian James	Rotherham Foundation Trust
Councillor Lakin	Cabinet Member for Safeguarding Children and Adults
Jo Pollard	NHS Doncaster
Chris Stainforth	NHS Doncaster
Joyce Thacker	Strategic Director, Children and Young Peoples' Services
Alan Tolhurst	NHS South Yorkshire and Bassetlaw
David Tooth	Chair, Rotherham CCG
Janet Wheatley	Voluntary Action Rotherham
Dawn Mitchell	Committee Services, RMBC

An apology for absence was received from Helen Watts (NHS Rotherham) .

S23. MINUTES OF PREVIOUS MEETING

Agreed:- That the minutes be approved as a true record.

Arising from Minute No. S15 (Armed Forces Community Covenant), Brian James, Rotherham Foundation Trust, reported that Juliet Greenwood, Chief Nurse, had been appointed as lead for the organisation and was the main contact with the armed forces. Information had been received and was being pursued.

It was noted that Dr. Nagpal Hoysal was the lead from NHS Rotherham and Christine Majer from the Local Authority. At present Councillor Hussain, Cabinet Member for Community Development, Equality and Young Peoples' Issues was the lead Member but, once signed off, would transfer to Councillor Doyle, Cabinet Member for Adult Social Care.

It was reported that veterans and serving officers who had been provided with psychological support by the NHS and MoD up to the present time would no longer receive such support after 6 months when some would still be in need of support.

Christine Boswell, RDaSH, reported that Carol Hurst would be their lead for this issue and would make her aware of the above issue.

S24. MEXBOROUGH MONTAGUE HOSPITAL

Jo Pollard, Programme Director, and Chris Staniforth, Chief Operating Officer, NHS Doncaster, gave the following powerpoint presentation on the proposals to change some services currently provided at Mexborough Montague and Tickhill Road Hospitals and provide more care closer to home:-

Why do we need to make these changes?
- More care can now be provided outside hospital
- NHS landscape and role of hospitals is changing
- What patients tell us
- New technology
- Improve quality and experience

Our Principles – Services must be
- Safe
- Effective
- Affordable
- Value for money
- Sustainable
- Integrated
- Local where possible

Government's four tests – Any service change must have
- Support of local GPs
- Patient and public engagement
- Clinical evidence
- Consistent patient choice

What about the money?
- No reduction in investment – just used differently
- New Rehabilitation Centre with £4.9M costs at Montague Hospital
- DBHFT build and equip the new Rehabilitation Centre including an application to the Fred and Anne Green Legacy
- Maintain the current investment of £2.8M on acute care
- £1.4M will be invested in additional home support services
- £400,000 will be invested in intermediate care and step down services
- £300,000 will be invested in community stroke services
- £500,000 will be invested in other community services and palliative care

Our Proposals 1 – A redesign programme to
- Reduce the time patients spend in hospital by providing high quality care for patients who do not need a hospital bed, at home or in a community setting

Our Proposals 2
- Reduce the time patients spend on an acute hospital ward by developing a new 58 bed state-of-the-art rehabilitation centre at Montague Hospital which would improve outcomes for patients by enabling an intensive 24/7 model of care to be delivered

Our Proposals 3

- Stop admitting to Montague Hospital those patients who were currently brought by 'blue light' ambulance for urgent care
- Take urgent care patients directly to Doncaster Royal Infirmary or another district general hospital near to where they live such as Barnsley and Rotherham

Why do we need to make changes?

- People are living longer so we need to help them stay as fit as possible so they can enjoy a fulfilled life
- Keeping elderly and frail patients in hospital beyond their urgent care period results in them losing many every day skills and this can quickly result in a loss of independence
- Centralising rehabilitation services at Montague Hospital would maximise the benefit of having a large pool of skilled therapists who would be able to provide a 7 day a week service
- More patients would be cared for at a single location instead of therapists spending valuable time travelling between hospital sites to see patients
- Patients who need urgent care should be treated at a facility that has a full range of support services
- An enhanced new role for Montague would enable the hospital to continue to flourish and secure its future at the heart of the Doncaster community

The Service redesign would

- Cut the time that patients stay on a ward in a busy hospital by faster access to specialist inpatient and community based rehabilitation services that would help speed up their recovery
- Improve health outcomes by helping patients get quickly back into everyday life
- Provide more social care support and services that provide 'intermediate' care for people who do not need a hospital bed but were not quite ready to return home
- Pilot a new assessment unit designed to speed up the discharge of people from hospital into the next stage of their care
- Provide more home support services
- Community based 'outreach' services to provide more care at home for people who have had a stroke to help prevent them from having another 1
- Create a new centre of excellence for rehabilitation at Montague Hospital bringing together a wide range of skilled clinical staff on 1 site
- Enable the closure of Ash, Elm and Rowan Wards at Tickhill Road Hospital and their service transfer to Montague

The change would also enable the local NHS to

- Do more surgery at Montague Hospital, cutting the time that patients had to wait for an operation
- Double the number and type of endoscopy procedures at Montague Hospital

Beds

- 160 (out of 872) beds affected by the proposals
- Reduction in Doncaster beds of 73

15 to Rotherham/Barnsley
50 beds or equivalent in community
8 achieved by reduced length of stay

What happens next?

- Public consultation finishes on 19th December, 2011
- All the responses would then be considered by senior NHS staff and summarised in a report
- The report would make recommendations and explain how your views had been taken into account
- Presented to the Board of NHS South Yorkshire and Bassetlaw in early 2012 for members to discuss and make a decision on whether the proposals should be implemented
- The date of the Board meeting would be publicised. The Board's decision would be publicised in the local media and published on NHS websites

Discussion ensued on the presentation with the following issues raised/clarified:-

- The Dental Access Service was a South Yorkshire resource for anyone to use. Presently it was delivered from Mexborough Montague, however, it would move from the Hospital site and move to 1 of the Health Centres in Mexborough

- The pilot phases would be based at the Tickhill Road site

- The need to invest in community services and social care services

- 2 of the physicians were retiring and, under the Royal College Guidance, unless a stand alone unit provided back up services, they could not recruit; Mexborough Montague did not have a back up service

- Rotherham Foundation Trust had been working with NHS Doncaster and in general supported the proposals and could absorb the anticipated impact

- RDaSH had also been working closely with NHS Doncaster around the proposed changes and linkage between the specialist unit at the Hospital and community based rehabilitation was critical. It was felt that the proposals helped to sustain the Hospital's future and gave it a clear role removing areas of concern around clinical evidence and developed the rehabilitation hub for that area

Chris and Jo were thanked for their presentation.

Resolved:- That a report on the proposals for the Dental Access Service be submitted to a future meeting.

S25. ROTHERHAM COMMUNITY STADIUM

Paul Douglas, Chief Operating Officer, and Brian Chapple, Rotherham United Football Club, were in attendance at the meeting to give a brief outline of the work of the Rotherham United Community Trust, the new Stadium and

examples of health facilities within stadia.

Rotherham United Community Trust – formed in 1997
Mission Statement – "to utilise the brand of Rotherham United Football Club and the power of sport to positively influence and enhance the diverse livestyles of the people of Rotherham"

- Education
  - Classrooms currently in temporary facilities – developed in partnership with public and private partners
  - 51 apprenticeships working out of the GOALZ Centre – commended for the retention rates
  - Working across the Borough on issues such as anti-bullying and anti-truancy

- Participation
  - Working in number of primary schools across the Borough delivering coaching where it might not otherwise be delivered
  - Players actively delivering mentoring

- Cohesion
  - Full-time officer
  - Just received "Kick It Out" Equality Standard, the industry standard for football. This had only been awarded to 30 clubs out of 90 and Rotherham was the only Club at its tier to receive the Award

- Volunteering
  - 1 of only 8 Clubs in the football world invited to pilot the National Citizen Service Programme and awarded the Leader of Best Practice nationally for the work the Club had led on
  - Currently there were 51 volunteers

- Disability
  - The Disability Officer ran regular sessions for those with additional needs through the partnership with RMBC, ILS and Voluntary Sector Consortium
  - "Aiming High" project engaged over 40 young disabled people every week. Afterschool coaching delivered
  - Healthy Hearts Programme set up to deliver multi-sport, diet and nutrition sessions for disabled adults

- Heritage
  - Call to Goal – an inter-generational project run last year looking back at the 1940-50's that was now being rolled out as an educational package
  - A further 2 heritage projects currently taking place which would be turned into education projects
  - Official Historian had been appointed who was very knowledgeable about the Football Club and was working closely with the Heritage Project Officers. There would be lots of examples in the new Stadium

- Health
  - Wake Up Shake Up – Sessions took place prior to the school day promoting the importance of eating a good breakfast and giving children

aged 7-11 years the opportunity to take part in some light exercise
- Extra Time delivered in 4 care homes
- Allotment project

It was stressed that the Trust had not been established due to the new Stadium but had been working for a number of years without any facilities delivering outreach work; the new Stadium would only improve and enhance its work. It had taken a long time to get to the present situation with the Stadium but the Chairman had been clear that it had a role to play in the community.

Numerous meetings had taken place with organisations to explore and maximise the opportunities the Stadium could bring. Those discussions now needed to be confirmed to help shape the design of the space.

The Trust had carried out a massive amount of work in the communities; the challenge for the future was to capitalise on it and link it to use of the facilities.

Discussion ensued with the following points raised/clarified:-

- Consideration had been given to use of the Stadium to music events etc. but felt that there was sufficient facilities in the area as well as engineering design issues
- National Time for Change Campaign – tackling anti-stigma in mental health and the connection with sport. Some work was currently carried out with Doncaster Rovers
- Linking in with Mental Health Charity "Breakthrough" – display of artwork produced by those suffering with mental health. Sheffield United were part of the scheme

Paul and Brian were thanked for their presentation.

S26. SPORT ENGLAND

The Chairman submitted Sport England information from their Our Active People Survey which provided local level data on sporting participation.

The mini sport profile gave key sporting data for the local authority area, the costs of inactivity and maps modelled on participation data and obesity date showing any direct correlation. The Active People Survey and Local Sport Profiles were valuable tools when developing or refreshing the Joint Strategic Needs Assessment.

Sport for England's existing work through Places People Play would bring the sporting legacy to life, delivering better facilities, more volunteers and greater access to a variety of sport across the whole country. More information on Places People Play could be found at www.sportengland.org.

The Local Sport Profile showed;-

- 19.9% of adults in Rotherham took part in sport and active recreation – national average 22%. 53.6% of adults did no sport or active recreation at all
- 3.7% adult residents were regular sports volunteers – national average

4.5%
- 21.1% were members of sports clubs – national average 23.9%
- The health costs of inactivity in Rotherham was at least £4.4M per year
- Sport contributes economically to the community with 55 businesses trading in sporting goods or services
- Youngsters who were active had numeracy scores, on average 8% higher than non-participants

Sport England's team of local experts, resources, tools, networks and investment were available to local authorities to help:-

- Achieve efficiencies and improve the effectiveness of service
- Evaluate and plan what sporting provision needed and where to meet a wide variety of local needs
- Establish partnerships with local sporting organisations to make investment go further
- Capitalise on opportunities to work with national governing bodies who were investing public money in communities
- Identify opportunities to bring the Olympics and Paralympics to life for communities through their Places People Play mass participation legacy programme
- Provide opportunities for young people to take part in the school Games and Sportivate

Resolved:- That the report be noted.

S27. DIABETES SCRUTINY REVIEW

Kate Green, Scrutiny Officer, presented the Scrutiny Review report on the diagnosis and management of Diabetes in Rotherham.

It was noted that the report had been considered by the Cabinet. The Cabinet had agreed that any future health-related Reviews be considered by the Board to ensure feedback to the relevant organisation and inclusion in the Health and Wellbeing Strategy. The Board would then be responsible for the implication and monitoring of the Review recommendations.

There were approximately 11,600 people diagnosed with Diabetes in Rotherham with around 4,000 undiagnosed cases highlighting the need for awareness raising and education in relation to early symptoms in high risk groups. Obesity and unhealthy lifestyles were prevalent in Rotherham along with high levels of deprivation. Raising awareness of the risk factors and focusing on prevention was needed to reduce the rise in Diabetes.

John Radford reported that NHS Rotherham had worked quite closely with Scrutiny to produce the report which aligned with the work that the CCG and NHS Rotherham were doing around prevention work.

The report set out in broad terms the framework being pursued in Rotherham to prevent and identify Diabetes through health checks and then improving the service for those diagnosed. Dr. Nagpal Hoysal was working across the system to try and support patients in the community and follow their treatment.

There was discussion in relation to scrutiny review recommendations and the need for all organisations to be involved in the development of these to ensure a collaborative approach. However, it was noted that the Board had not been in existence when the Review had taken place, therefore the agreement above for scrutiny review scopes to come to the Board prior to them taking place would ensure this happens in future.

Agreed:- (1) That the report be noted.

(2) That the Board consider the recommendations and ensure inclusion in the joint Health and Wellbeing Strategy once in place, along with subsequent commissioning plans.

(3) That the process for future reviews be mapped out to demonstrate how scrutiny would work with the CCG and NHS organisations.

S28. FOOD BANK/AWARENESS WORK

Janet Wheatley, VAR, gave a verbal report on a meeting that had recently taken place regarding the above. This had been as a result of enquiries received relating to people who were in crisis and could not access food.

A group of organisations had met – homeless charities, Salvation Army, Food Bank, NHS and the Council. It soon became apparent that it was a much bigger issue than envisaged and was not just food for people in crisis but food for vulnerable people particularly children, young people and the elderly, issues around eat or heat, healthy cooking skills and growing your own food.

Information was to be sent out to service providers on how people in crisis could access food and also ascertain from providers what was available. An Expression of Interest had also been submitted to the Big Lottery to develop a project around growing and selling produce, linking in with the Rotherham United Football Trust etc. The proposal had been accepted at the first stage and an application form now had to be completed. 18 partners were involved in the project and, even if the application was not successful, it was hoped to be the basis of some further work.

A further meeting was to be held the following day.

Agreed:- That a further report be submitted to a future meeting.

S29. WINTER PLAN

John Radford, NHS Rotherham, reported that the Winter Plan arrangements for Rotherham were in place across partners to ensure all had measures in place to protect the town during the winter.

There were already reported cases of flu in Rotherham and 1 unconfirmed flu related death. The number of flu vaccinations was lower than last year particularly in the at risk groups and pregnant women.

Rotherham Foundation Trust had 1 of the highest staff vaccination rates in the region which was a great achievement.

S30. INTEGRATED STRATEGIC NEEDS ASSESSMENT

This item was withdrawn.

S31. TERMS OF REFERENCE/MEMBERSHIP

In accordance with Minute No. S14, the revised Terms of Reference were submitted for consideration incorporating the suggested comments made at the previous meeting.

In light of the previous agenda item, Diabetes Review, the Chairman suggested that an additional bullet point be added under 2.2 Operating Principles as follows:-

(I) Health and Wellbeing Scrutiny Reviews - scoping of /progress of

Agreed:- That the revised Terms of Reference be agreed.

S32. COMMUNICATIONS

Flu vaccinations – publicity

Health Inequalities Summit – initial findings very well received by the 3 local Members of Parliament

S33. FUTURE AGENDA ITEMS

NHS Operating Framework
Drinking of Alcohol in Rotherham
Health Inequalities Summit
NHS Outcomes Framework
JSNA/Working Programme 2012/13
Targeting Resources in Deprived Areas
HealthWatch
Communications Support for the Board

S34. DATE OF NEXT MEETING

Agreed:- That a further meeting be held on Wednesday, 18th January, 2012, at Oak House, Bramley.

Drinking Alcohol in Rotherham

Anne Charlesworth
Head of Alcohol & Drug Strategy Team
Public Health
NHS Rotherham

19th October 2011

Dear Colleagues

Specialist Alcohol Commissioning Meetings Feedback

We would like to take this opportunity to thank you and your colleagues for meeting with us recently to discuss specialist alcohol commissioning in your area and to offer some feedback as a response to that meeting.

Firstly, we would like to recognise the progress that your local approach has made with the alcohol agenda, with a particular focus on commissioning to the evidence base and working well in partnership across the agenda. In particular, we would like to highlight the strengths in Rotherham;

The strong commissioning profile which has facilitated excellent engagement across primary care.
Integration across all substance misuse provision raising the skills and competencies of the workforce.
Embracing a clear recovery orientated vision at both strategic and delivery level.
Clear clinical pathways supported by regular and robust negotiations with partners
A shared sense of responsibility has been fostered which has improved joint working.
Improving outcomes despite significant increases in demand.

There were also a number of action points raised including;

Clarification required regarding costings information and outcome monitoring tools within the PbR pilot which will be ongoing.

Although we recognise that we are working in complex times and that the partnership horizon is rapidly changing, we would like to commend the work you have been engaging with to date and ask that you continue attending the Regional Alcohol Network meeting on a quarterly basis to assist with the agenda.

If you have any queries or need any additional information please do not hesitate to contact the NTA on the number above.

Yours sincerely

Corinne Harvey
NTA Regional Manager

Dianne Draper
Alcohol Policy Lead YH

NHS
National Institute for
Health and Clinical Excellence

Benchmark activity

Total Population Selected	244,053		
Population aged 16 years and over	196,719		
Benchmark rates of alcohol misuse	**Standard assumptions**	**Locally adjusted assumptions**	**Benchmark number of people per condition**
Population selected (16+)	196,719	196,719	
Hazardous and harmful drinkers - rate per 100,000 population	24,200	24,200	47,606
Harmful drinkers - rate per 100,000 population	3,800	3,800	7,475
Dependent drinkers - rate per 100,000 population	2,600	2,600	5,115
Benchmark activity			
Specialist alcohol treatment services	**Standard assumptions**	**Locally adjusted assumptions**	**Number of people receiving specialist treatment**
Number of people with alcohol dependence	5,115	5,115	
Current percentage receiving specialist treatment	10.2%	10.2%	522
Future percentage receiving specialist treatment	15.0%	15.0%	767
Benchmark number of people receiving specialist treatment	**767**	**767**	

Alcohol-related hospital admissions	**Standard assumptions**	**Locally adjusted assumptions**	**Benchmark activity per condition**
Population selected (total population)	244,053	244,053	
Alcohol-related hospital admissions - rate per 100,000 population	1,743	1,743	4,254
Benchmark number of alcohol-related hospital admissions	**4,254**	**4,254**	

Note	
1	See commissioning guide section 5: 'Determining local service levels for the identification and treatment of alcohol misuse'. The benchmark rate for harmful drinking is around 3.8% per 100,000 of the population aged 16 years and above. Around two thirds of harmful drinkers show signs of alcohol dependence – equivalent to 2.6% or 2,600 per 100,000 of the population aged 16 years and above.
2	Data from the National Treatment Agency for Substance Misuse (2010) shows that around 111,000 dependent drinkers receive specialist treatment for alcohol misuse. This is equivalent to about 10.2% of the 1,090,000 people who scored more than 15 on the Alcohol Use Disorders Identification Test (AUDIT) and who score 4 or above on the Severity of Alcohol Dependence Questionnaire – Community version (SADQ-C) Available from: Statistics from the National Alcohol Treatment Monitoring System (NATMS) 1 April 2090-31 March 2010
3	NICE Public Health guidance 24 on preventing harmful drinking recommends that: Commissioners should ensure at least one in seven dependent drinkers can get treatment locally, in line with 'Signs for Improvement'. This is equivalent to around 15% of people with alcohol dependence receiving specialist treatment each year.
4	The North West Public Health observatory analysis of HES data for alcohol-attributable hospital admissions. Available from: http://www.nwph.net/alcohol/lape/download.htm The North West Public Health observatory website also provides regional analysis of alcohol-related months of life lost and alcohol related mortality.

Alcohol – some of the latest initiatives

Message to wider population

•Call it a Night website (now includes screening tool for use by anyone to assess what constitutes increasing risk by young people drinking behaviour, can be used by young people and in education settings

•Picking up young people presenting at A&E and making sure school nursing follow this up (or specialist services if 16-18 years)

•Alcohol Awareness Week events

•Staff Training (including staff at Hellaby and Hargreaves Colliery) via the commissioned workplace initiative with Lifeline

•Identifying alcohol use levels via Police Custody Suite

•Street Pastors have a crucial role in reducing alcohol related harm

Alcohol Services

•Currently one of four areas undertaking National Payment by Results pilot for Department of Health

•From next year will increase target to include more ‘problem’ drinkers and more ‘Tier 2’ intervention (with less money).

•Staff numbers reduced

•Primary Care Scheme now includes all but five practices

•Lifeline continue to exceed targets to offer assessments and interventions, both stand alone and to support NHS agenda

•Case management of high impact users of hospital and ambulance services

•Improved collaboration between hospital care and specialist services

NHS Rotherham

Health and wellbeing Board January 2012

Rotherham Cold Weather Plan: Incorporating the Winter Plan and Affordable Warmth

Contact Details:			
Lead Director:	**John Radford**	**Lead Officer:**	**Jo Abbott/ Dominic Bladen**
Title:	**Director Public Health**	**Title:**	**Consultant in Public Health**

Purpose:

The report sets out winter planning arrangements for health and social care in Rotherham. It incorporates Rotherham's response to the Cold Weather Plan , issued in October 2012 .The Affordable Warmth Strategy is currently being refreshed and this has been incorporated into it thus ensuring all plans are "joined up".

Recommendations:

It is recommended that the Health and Wellbeing Board.

- Endorse The Rotherham Winter Plan (attached)
- Note the arrangements that have been put in place to cover winter pressures and extreme weather.
- Note the year round arrangements in place via the Affordable Warmth Strategy

Background:

The NHS Yorkshire and the Humber Footprint Winter Planning Framework (September 2010) sets out the responsibilities of PCTs in relation to winter planning. PCTs are expected to:

- Have an internal escalation process in place for reporting and management of events and serious incidents including performance and media issues relating to the PCT and commissioned services.
- Have systems in place to monitor winter pressures and take action to maintain 'business as usual'.
- Have systems and processes in place to support the local health economy with managing and mitigating any increase in demand to ensure patient and staff safety and outcomes.
- Ensure that it follows that Yorkshire and Humber pre-escalation system as part of its escalation process.

The NHS Cold Weather Plan for England sets out what should happen before and during severe winter weather in England. It spells out what preparations both individuals and organisations could make to reduce health risks and includes specific measures to protect at risk groups. The

cold weather plan depends on having well co-ordinated plans in place for how to deal with severe cold weather before it strikes, including the following essential elements:

- Strategic planning across partner organisations and at a national and local level
- Advance warning and advice during the winter months through a Cold Weather Alert service
- Communicating with the public encompassing general duties under the Civil Contingencies Act 2004
- Helping GPs and community services to identify vulnerable patients
- Ensure providers implement measures to protect people in their care
- Ensure staff are fit and well by supplying flu vaccinations to front-line health and social care workers.

Analysis of Risks:

Winter Plan

Last winter presented the local health community with significant challenges. There was a severe weather event at the beginning of December when heavy snow affected the borough. This was followed by a busy bank holiday period, a significant outbreak of the swine flu virus and a follow-on outbreak of the norovirus at the hospital. Despite these pressures there was limited disruption of services. GP Practices in particular provided significant support during the periods of high demand and disruption. All service providers were able to remain open through the snow and ice and then maintained services during the holiday period.

The events of last year were unprecedented but Rotherham FT was still able to maintain service throughout the winter period. This year there is a significant additional risk with the current high levels of emergency admissions. A&E attendances are higher than this time last year as are conversion rates. If Rotherham were to experience a similar spike in demand this year during the winter period the hospital may find it difficult to maintain bed availability.

There were significant issues with the Walk in Centre during 2010/11. The Centre had to close on 7 occasions during the Christmas and New Year period because of spikes in demand. Activity levels for the Walk in Centre reflected those for A&E. There was a 23% increase in activity over the whole period. From Week 52 to week 2 there was a 45% increase in demand compared to the previous year. The spike in demand during early January reflects the situation at A&E.

Care UK has introduced a series of measures to deal with spikes in demand at the WIC. These include;

- Introduction of an appointments system to help spread demand
- Introduction of a single point of contact to filter out inappropriate attendances
- Enhancement of nurse triage and increase in patient flow through the service

The Cold Weather Plan sets out what would happen in Rotherham before and during severe winter weather. It spells out what preparations Rotherham organisations can make to reduce health risks and includes specific measures to protect at risk groups. An E mail “cold weather alert” has been set up by the Met office to key people across Rotherham to help plan in the days before extreme weather is forecast. A robust communication plan has been developed, including to the public about how they can help themselves, and professionals/ providers.

The affordable warmth strategy focuses more on prevention and work is carried out all

year round. A community action plan is currently been developed with Age Concern taking a key role. Individuals are advised to insulate their homes and water pipes and check their entitlement to benefits and local grants. Lessons learnt from the successful "Keeping Warm in Later Life" project (KWILLT) have also been incorporated. The public are advised to have the annual flu jab.

Return on Investment:

NHS Rotherham has made significant investment into services through reinvestment of 30% marginal tariff and use of reablement grant. These investments are primarily aimed at reducing emergency admissions during the winter period. Initiatives include;

- Expansion of the Fast Response
- Introduction of nursing support into Intermediate Care
- Development of a community stroke service
- Development of a dementia support service for patients discharged from hospital
- Enhancement of the home care enabling service
- Development of a Virtual Ward

These initiatives are currently operating as pilots and will be reviewed in March 2012.

The Cold Weather Plan has a comprehensive communications strategy advising the public how they can help themselves during periods of extreme cold weather thus preventing unnecessary hospital admission.

Analysis of Key Issues:

NHS Rotherham

The Surge and Mass Discharge Plan has been reviewed and agreed for use by NHS Rotherham in collaboration with partner organisations. The plan is primarily based on supporting health care organisations to manage significant increase in demand in the event of a surge. The plan has been devised and agreed with partners and stakeholders. Once the surge plan has been triggered mechanisms will be put in place to increase patient flow.

QIPP and Reablement schemes have been developed over the autumn to help address winter pressures. These will help to support patients within the community, preventing avoidable hospital admissions and facilitating early discharge.

A Winter Single Point of Contact for patients has been set up to provide signposting, advice and triage for patients to try and reduce attendances at A&E. This will be run by Care UK who will be able to book appointments for patients at the WIC where appropriate.

Rotherham FT

A robust action plan has been developed following issues raised from last year in relation to bed pressures and the severe adverse weather.

Rotherham FT is confident that it will be able to respond to the demand over the winter. Contingency arrangements are in place to ensure urgent elective work will continue during times of unexpected pressure. There is an expected reduction in bed occupancy over the Bank Holiday period due to natural reduction in elective activity. The Trust has an escalation plan for In-Patient medical beds, and Accident & Emergency and Medical Assessment Unit within their Patient Flow Policy for Adults.

Regarding the threat of industrial action by staff, RFT services have Business Continuity Plans in place to manage and prioritise services due to loss of staff.

Rotherham FT has undertaken a reconfiguration of medical beds. The merger of the two existing Clinical Service Units (General Medicine and Healthcare for Older People) will accommodate up to 40 additional surge beds at times of peak demand. A robust policy is in place for opening these additional surge beds.

Rotherham FT has worked closely with commissioners to reconfigure community health services so that they are better able to address winter pressures.

The Fast Response Service has been extended, providing a significant presence at A&E and B1. As part of the Alternative Levels of Care (ALC) work stream, the Fast Response service will lead on diverting patients at the point of entry to hospital into an alternative level of care. From November the Fast Response Team will have a base at A&E. Utilising Interqual the team will be able to identify those patients who do not require admission to hospital. They will co-ordinate the most appropriate level of care in the community and ensure safe hand-off to the relevant community services.

The in-patient service at Breathing Space will be open 24 hours a day, 7 days a week and will remain open over the Christmas bank holiday period. New protocols are currently being developed to ensure that Breathing Space is able to provide step-up support to patients who have been assessed by Interqual as not requiring hospital admission.

Rotherham FT Community Services have recently reconfigured their community nursing teams so that they are more responsive to the needs of patients at risk of hospital admission. District nursing teams have been merged with the community matron service to create locality based community health teams. These teams are GP facing, and realigned so that they are better able to support patients with long term conditions, particularly those in exacerbation.

Rotherham FT has also been working closely with commissioners to develop three Virtual Wards in Rotherham which will provide an alternative to hospital care. These wards will enhance care for people with multiple long term conditions and/or those at high risk of acute admission.

Rotherham MBC

Rotherham MBC has worked closely with NHS Rotherham this year to reconfigure services so that they respond more effectively to winter pressures.

The Council has realigned the Intermediate Care Service so that it takes a greater proportion of referrals from Fast Response. Using Reablement Grant the Council has developed a bank of care enablers who can provide additional support to the residential service during peak demand

periods. Working alongside RFT community health services Intermediate Care is also now able to take a different profile of patients who are at high risk of hospital admission. This reconfiguration should enable Fast Response to divert patients from A&E and B1 away from hospital and into an alternative level of care.

Rotherham MBC now has a substantial social work presence in Intermediate Care. Social workers are available to work alongside the Fast Response Service over the winter period. These social workers will help expedite discharge from A&E, CDU and the Medical Assessment Unit. As well as increasing bed availability during winter it will reduce admissions and increase likelihood that some admissions will only incur a short stay tariff.

Rotherham MBC has provided assurance that the hospital social work team has appropriate plans in place to ensure continuity of service during the winter period. The Council has performed well this year in terms of delayed discharges from hospital. Last winter, despite extreme pressure during early January there were no issues relating to delayed discharges.

Patient, Public and Stakeholder Involvement:

Communications on winter planning arrangements will reflect those of last year through Choose Well and the material regarding the local Single Point of Contact. Advice to the public will be carried out through local press and via front line staff.

The draft Cold Weather Plan/ Winter Plan has been to the Joint Health and Social Care Emergency Planning group and the Affordable Warmth Steering group. It has also been to Rotherham Clinical Commissioning group.

Equality Impact:

Ensuring that robust winter plans are in place is key to the more vulnerable members of the community.

Financial Implications:

The financial consequences associated with the risks highlighted in this paper are currently accounted for in the forecast out-turn reflected at Month 7 (Winter Plan 2011/12).

Should any of the actions highlighted in this paper to mitigate the impact of winter not have the desired effect in terms of activity control then there will be a direct financial consequence due to the mechanisms of the PBR system. This could have the result of increasing our expenditure with our main providers beyond that currently forecast.

Approved by: John Doherty

Human Resource Implications:

TRFT has considered the possibility of industrial action that could impact on delivery of service and has reviewed workforce plans to ensure essential functions will be maintained.

Approved by:

Procurement:
There are no procurement implications.
Approved by:

Key Words:
Winter Planning Cold Weather Plan Affordable warmth

Further Sources of Information:
Jo Abbott Consultant in Public Health x2156

VERSION 23.11.11

2011/12

NHS Rotherham Winter Plan

Incorporating The Cold Weather Plan for England 2011

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1. PURPOSE OF THE REPORT

This report sets out winter planning arrangements for health and social care in Rotherham including resources and capacity put in place to manage the impact of winter pressures which includes the Christmas and New Year holiday period. The report incorporates Rotherham's response to the National Cold Weather Plan 2011/12 issued in October of this year.

The Strategic Health Authority requires NHS Trusts to approve their winter planning arrangements at Executive Team Level and to provide assurance that all NHS organisations within our borough have reviewed their capacity and capability to manage any expected increase in demand for the Winter Period.

2. STRATEGIC FRAMEWORK

Local winter planning arrangements are formulated around 2 key frameworks.

2.1 NHS YORKSHIRE AND HUMBER WINTER PLANNING FRAMEWORK

The NHS Yorkshire and the Humber Winter Planning Footprint Framework (September 2010) sets out the responsibilities of PCTs in relation to winter planning. PCTs are expected to:

- Provide a leadership and co-ordination role to the local health community in planning for winter, supporting and working with organisations to ensure they have risk based plans in place to meet the challenges of winter.
- Ensure that organisations providing NHS Commissioned care fulfil their contractual duties in relation to both business continuity planning (capacity and capability, maintenance of critical services) and winter preparedness (sit rep reporting, escalation process)
- Ensure that the PCT's own escalation plans for dealing with pressures recognises the higher-level requirements of winter preparedness
- Take the appropriate management action where pressures in the local health system impact on service delivery.
- Ensure that there are clear protocols for the co-ordination of the health and social care economy in order to maximise the use of community bed capacity in liaison with local acute hospitals and any available local bed management system
- Monitor the impact of winter on vulnerable groups, such as children, dialysis patients, elderly, medical or physical dependency and mentally health patients.

2.2 THE NHS COLD WEATHER PLAN FOR ENGLAND

The NHS Cold Weather Plan for England sets out what should happen before and during severe winter weather in England. It spells out what preparations both individuals and organisations could make to reduce health risks and includes specific measures to protect at risk groups.

The cold weather plan depends on having well co-ordinated plans in place for how to deal with severe cold weather before it strikes, including the following essential elements:

- *Strategic planning* across partner organisations and at a national and local level to prepare for pressures on the health system. Also planning for future impact of climate change on winter weather and increasing energy efficiency measures.
- *Advance warning and advice during the winter months* through a Cold Weather Alert service based on Met Office forecasts. Also advice and information from the Department of Health for the public and health and social care professionals, particularly those working with at-risk groups.
- *Communicating with the public* encompassing general duties under the Civil Contingencies Act 2004, working with the media, raising awareness of how cold weather affect health and what preventative action people can take, and Keep Warm Keep Well campaign material.
- *Communicating with service providers* by helping GPs and community services to identify vulnerable patients, ensuring providers implement measures to protect people in their care, and to ensure staff are fit and well by supplying flu vaccinations to front-line health and social care workers.
- *Engaging the community* through providing extra help to those at risk as part of the person's individual care plan. Also additional help to signpost people who may be eligible to claim benefits.

Full detail of how the Cold Weather Plan for England is being implemented in Rotherham is explained under: 9. The NHS Cold Weather Plan for England – Rotherham .

3. LEADERSHIP AND CO-ORDINATION OF WINTER PLANNING

The leadership and co-ordination role set out in the NHS Yorkshire and the Humber Winter Planning Footprint Framework is carried out by Rotherham's Emergency and Urgent Care Network. The network incorporates senior management representatives from all urgent health and social care services in Rotherham. The remit of the network is to;

- To optimise the emergency and urgent care of all patients in the locality.
- Ensure that the patient perspective and quality of care are the priorities in planning emergency healthcare in the local health and social care community.
- To ensure a system wide care pathway approach to admission avoidance and discharge planning across the local health and social care community.
- To co-ordinate emergency health care across all organisations in a community
- To work with health and social care commissioners to determine priorities in emergency care
- To agree and develop local standards and protocols

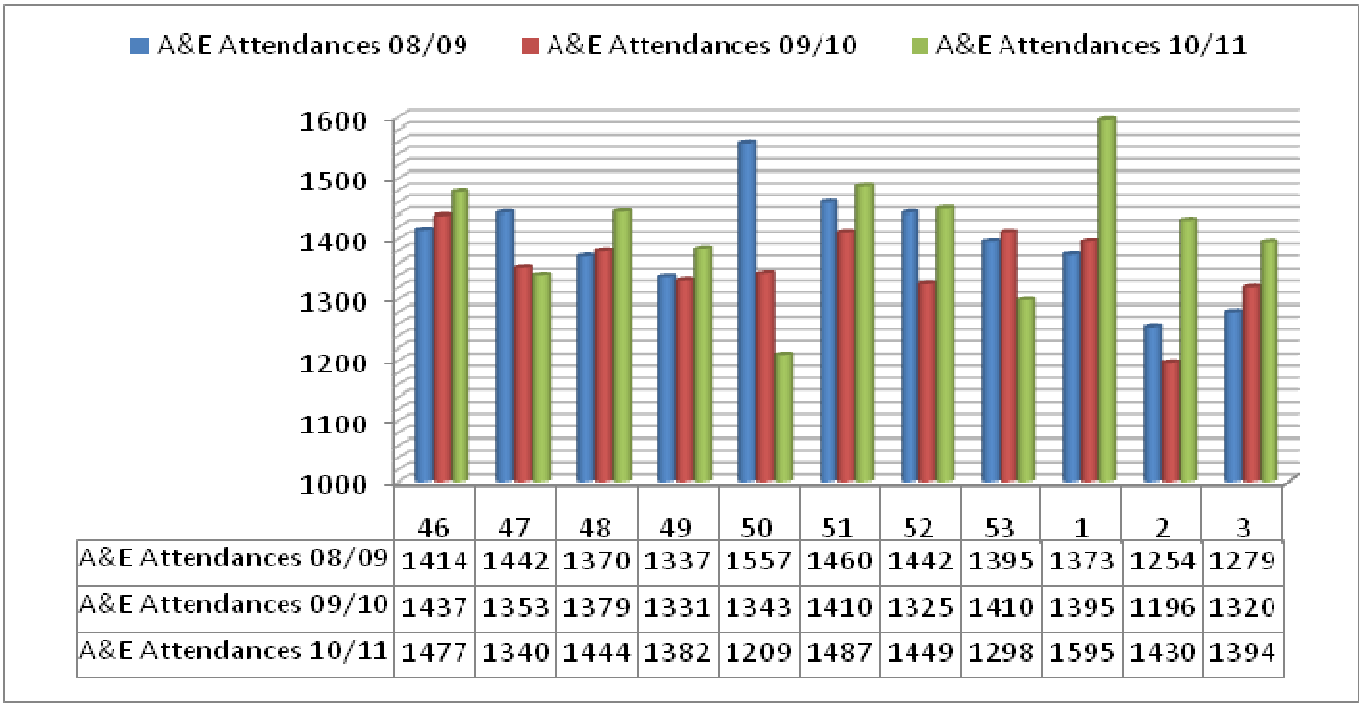
The Rotherham Emergency and Urgent Care Network meets monthly and aims to ensure integrated and effective care pathways for patients with emergency and urgent care needs. This enables a whole system approach for unplanned care, including winter planning. The network receives reports from partner organisations on winter planning arrangements and pressures in the local health system. It co-ordinates remedial action planning.

4. LEARNING FROM WINTER PRESSURES 2010/11

Last winter presented the local health community with significant challenges. There was a severe weather event at the beginning of December when heavy snow affected the borough. This was followed by a busy bank holiday period, a significant outbreak of the swine flu virus and a follow-on outbreak of the norovirus at the hospital. Despite these pressures there was limited disruption of services. GP Practices in particular provided significant support during the periods of high demand and disruption. All service providers were able to remain open through the snow and ice and then maintained services during the holiday period.

Figure 1 shows the A&E activity for the period 5.12.10 to 16.1.11 during the last 3 years. It shows a significant spike in activity throughout the first half of January.

Figure 1: A&E activity



	46	47	48	49	50	51	52	53	1	2	3
A&E Attendances 08/09	1414	1442	1370	1337	1557	1460	1442	1395	1373	1254	1279
A&E Attendances 09/10	1437	1353	1379	1331	1343	1410	1325	1410	1395	1196	1320
A&E Attendances 10/11	1477	1340	1444	1382	1209	1487	1449	1298	1595	1430	1394

Table 1 shows the total number of attendances at A&E for Quarter 3 split by disposal.

Table 1: A&E attendances split by disposal

	No follow up	GP follow up	Admitted	Fracture clinic	Other	Total
Number	1477	1009	833	315	710	4344
Percentage	34%	23%	19%	7%	17%	

From Table 1 it can be seen that 57% of A&E attendances either received no follow up or were referred to their GP. This is the cohort that could have been diverted to the Walk In Centre.

GP services were subject to unprecedented pressure as a result of severe weather in December. GP practices went to great lengths to remain open through the snow and ice. They were able to maintain services during the holiday period and continued to deliver services in a hostile environment.

The bed status at Rotherham FT during the Christmas period was good. There was bed availability throughout the Bank Holiday weekend and A&E activity was lower than previous years, however, there were significant bed pressures after the New Year. Rotherham FT was running with 50 extra beds throughout the first half of January. Electives were cancelled for at least 3 days. Most of the extra demand for beds was coming through A&E. There was a significant increase in attendances and a greater proportion of these patients were admitted. Admissions were running at 22% to 26% during the first two weeks of January. This compares to 19% overall for Q3. There was substantial pressure on critical care beds with bed availability down to zero during peak demand periods.

Despite being under extreme pressure at times Rotherham FT only diverted patients on 2 occasions.

There were significant issues with the Walk in Centre during 2010/11. The Centre had to close on 7 occasions during the Christmas and New Year period because of spikes in demand. Activity levels for the Walk in Centre reflected those for A&E. There was a 23% increase in activity over the whole period. From Week 52 to week 2 there was a 45% increase in demand compared to the previous year. The spike in demand during early January reflects the situation at A&E.

5. MITIGATION ACTIVITY FOR 2011/12

NHS Rotherham carried out a full analysis of winter pressures in 2010/11. This report identified mitigating activity that had greatest impact and ensured these activities were formally built in for 2011/12.

5.1 INITIATION OF SURGE PLAN

The Surge Plan supports health care organisations to manage significant increase in demand in the event of a surge. The plan is invoked when:

- A service is so severely affected that it is unable to maintain its key functions without support from other service areas.
- The business interruption has affected more than one service and has potential to severely affect the overall key functions of the local health and social care community.

Initiation of The Surge Plan enables the following actions to be taken;

- It immediately reduces the threshold for admission to intermediate care, facilitating the discharge of patients who are medically fit but unsafe to return home
- Triggers interventions by community health services to support to the hospital discharge
- Places the Continuing Care Team on standby to carry out fast track social care assessments for patients waiting discharge
- Triggers the delivery of extra support from Rotherham MBC to fast track social care assessments, place patients in respite and initiate home care packages

Initiating The Surge Plan last year did assist Rotherham FT on hospital discharges. There was full co-operation from all of the local authorities support services.

5.2 EMERGENCY BED MANAGEMENT MEETINGS

Throughout the first two weeks of January Rotherham FT co-ordinated multi-agency bed management meetings. These provided an update on current bed status, specifically relating to critical care, paediatrics and A&E. The main aims of the meetings were to;

- Ensure there was significant capacity in intermediate care and Breathing Space
- Enlist the support of community health services on supporting secondary care
- Anticipate future pressures on the system such as staff sickness and hospital infections
- Identify patients who were fit for discharge and reasons for delays

These meetings provided a useful interface between service providers. There was good sharing of information and a breaking down of organisational boundaries. This multi-agency team was effective at ensuring that the hospital remained operational.

5.3 DAILY TELECONFERENCES

Last year NHS Rotherham co-ordinated daily teleconferences which brought together key stakeholders in the local health community. The main aims of the teleconferences were to;

- Inform stakeholders where there were pressures in the system
- Enlist community services support on maintaining secondary care services
- Ensure that community services focused on preventing hospital admissions

These conferences had a wider representation than the Emergency Bed Management meetings. They provided a useful source of information and helped commissioners to identify where support was required.

6. CAPACITY AND CAPABILITY OF URGENT CARE SERVICES

NHS Rotherham and partner organisations have submitted their winter plans for 2011/12. These are summarised below.

6.1 NHS ROTHERHAM

NHS Rotherham co-ordinate all local SITREP reporting. SITREP reports are submitted by the Rotherham Foundation Trust. Exceptions are reported via NHS Rotherham to the Cluster Executive Lead for Winter Planning.

The Surge and Mass Discharge Plan has been reviewed and agreed for use by NHS Rotherham in collaboration with partner organisations. The plan is primarily based on supporting health care organisations to manage significant increase in demand in the event of a surge. The plan has been devised and agreed with partners and stakeholders. Once the surge plan has been triggered mechanisms will be put in place to increase patient flow.

The Partnerships Team has collated plans from the provider organisations in the health and social care community. Feedback so far indicates that most providers are fully prepared and resourced to meet the demands of the winter period. A winter contacts and information pack for staff will be circulated to partner organisations and will include details of service opening times over the bank holiday period and emergency contact details for all partner organisations.

QIPP and Reablement schemes have been developed over the autumn to help address winter pressures. These will help to support patients within the community, preventing avoidable hospital admissions and facilitating early discharge.

A Winter Single Point of Contact for patients has been set up to provide signposting, advice and triage for patients to try and reduce attendances at A&E. This will be run by Care UK who will be able to book appointments for patients at the WIC where appropriate.

6.2 ROTHERHAM FOUNDATION TRUST - HOSPITAL

TRFT's winter plan will be approved and signed off by their Board by November 2011. The plan will include any learning from last year. The TRFT winter plan (November 2011 to October 2012) includes internal and external sitrep reports and an internal escalation plan for surges in demand. The escalation includes Trust Command and Control Battle Rhythm. Supporting Guidance Plan for Severe Adverse Weather (snow) is included as an appendix of TRFT's winter plan.

A robust action plan has been developed following issues raised from last year in relation to bed pressures and the severe adverse weather.

Rotherham FT is confident that it will be able to respond to the demand over the winter. Contingency arrangements are in place to ensure urgent elective work will continue during times of unexpected pressure. There is an expected reduction in bed occupancy over the Bank Holiday period due to natural reduction in elective activity. The Trust has an escalation plan for In-Patient medical beds, and Accident & Emergency and Medical Assessment Unit within their Patient Flow Policy for Adults.

Regarding the threat of industrial action by staff, RFT services have Business Continuity Plans in place to manage and prioritise services due to loss of staff.

The Rotherham FT has a detailed Fuel Shortage Plan in place that can be invoked by the Command and Control Team as required. Work is currently on going in-relation to updating the Fuel Plan. This will consider staffing profiles and distance to work. It will set out clear guidance to staff on expectation regarding walking distances and responses during extreme weather conditions.

Rotherham FT has undertaken a reconfiguration of medical beds. The merger of the two existing Clinical Service Units (General Medicine and Healthcare for Older People) will accommodate up to 40 additional surge beds at times of peak demand. A robust policy is in place for opening these additional surge beds.

Finally Rotherham FT have redefined the terms of reference of their Discharge Strategy Group to include the prioritisation of admission avoidance as well as the coordination of effective discharge planning for complex patients.

6.3 ROTHERHAM FT – COMMUNITY SERVICES

Rotherham FT has worked closely with commissioners to reconfigure community health services so that they are better able to address winter pressures.

The Fast Response Service has been extended, providing a significant presence at A&E and B1. As part of the Alternative Levels of Care (ALC) work stream, the Fast Response service will lead on diverting patients at the point of entry to hospital into an alternative level of care. From November the Fast Response Team will have a base at A&E. Utilising Interqual the team will be able to identify those patients who do not require admission to hospital. They will co-ordinate the most appropriate level of care in the community and ensure safe hand-off to the relevant community services.

The in-patient service at Breathing Space will be open 24 hours a day, 7 days a week and will remain open over the Christmas bank holiday period. New protocols are currently being developed to ensure that Breathing Space is able to provide step-up support to patients who have been assessed by Interqual as not requiring hospital admission.

Rotherham FT Community Services have recently reconfigured their community nursing teams so that they are more responsive to the needs of patients at risk of hospital admission. District nursing teams have been merged with the community matron service to create locality based community health teams. These teams are GP facing, and realigned so that they are better able to support patients with long term conditions, particularly those in exacerbation.

Rotherham FT has also been working closely with commissioners to develop three Virtual Wards in Rotherham which will provide an alternative to hospital care. These wards will enhance care for people with multiple long term conditions and/or those at high risk of acute admission. They will do this by;

- Building on the current clinical case management role of Community Nurses
- Using risk prediction techniques to focus activity on preventing exacerbation and avoidable acute admissions;
- Diverting patients at A&E and MAU so that they can receive appropriate care at home
- Embedding Virtual Wards in multi-disciplinary teams across health and social care

The Rotherham Virtual Ward will be one of the vehicles used to reduce emergency admissions and shorten length of stay. It will ensure that Integrated Adult Community Health Teams in Rotherham are organised with the patient at the centre, using a seamless approach to delivering safe, effective personalised care. Patients who are registered onto The Virtual Ward will be cared for by competent multi- disciplinary teams in the right place, at the right time and in the right location. These teams will be based geographically around GP Practices.

The service will be expected to provide both planned and unplanned care with a focus on the prevention of unnecessary admission to hospital or facilitating a more timely discharge from hospital. Care will be provided in partnership with other health and social care professionals including services provided by the third sector and will be available for seven days a week.

Each Virtual Ward will be led by a community physician working alongside community matrons. The Virtual Ward will be supported by Fast Response, Community Health Teams, the Care Home Liaison Service and Intermediate Care Service.

6.4 ROTHERHAM MBC – ADULT SOCIAL CARE SERVICES

Rotherham MBC has worked closely with NHS Rotherham this year to reconfigure services so that they respond more effectively to winter pressures.

The Council has realigned the Intermediate Care Service so that it takes a greater proportion of referrals from Fast Response. Using Reablement Grant the Council has developed a bank of care enablers who can provide additional support to the residential service during peak demand periods. Working alongside RFT community health services Intermediate Care is also now able to take a different profile of patients who are at high risk of hospital admission. This reconfiguration should enable Fast Response to divert patients from A&E and B1 away from hospital and into an alternative level of care.

Rotherham MBC now has a substantial social work presence in Intermediate Care. Social workers are available to work alongside the Fast Response Service over the winter period. These social workers will help expedite discharge from A&E, CDU and the Medical Assessment Unit. As well as increasing bed availability during winter it will reduce admissions and increase likelihood that some admissions will only incur a short stay tariff.

In Intermediate Care, the capacity and number of beds is believed to be sufficient to meet the anticipated demand over the winter period and will admit patients as part of the ALC scheme.

Rotherham MBC have provided assurance that the hospital social work team has appropriate plans in pace to ensure continuity of service during the winter period. The Council has performed well this year in terms of delayed discharges from hospital. Last winter, despite extreme pressure during early January there were no issues relating to delayed discharges. In fact Rotherham MBC worked closely with Rotherham FT to expedite the early discharge of a number of patients, helping generate additional capacity within the hospital.

6.5 GP, DENTAL AND PHARMACY ARRANGEMENTS

Arrangements are in place with GPs, Dentists and Pharmacists to ensure that people can access these services over the Christmas and New Year period. Pharmacy rotas have been completed and show a good spread of availability across the bank holidays. The Emergency Dental Service is also available for patients needing emergency dental treatment over this period.

6.6 CARE UK – URGENT CARE SERVICES

Care UK delivers the following urgent care services in Rotherham which are relevant to winter planning;

- GP Out of Hours Service
- The Rotherham Walk In Centre (WIC)
- The Winter Single Point of Contact

Care UK has worked with commissioners to identify compromises to Out of Hours and WIC functions through risk assessment. They have ensured that suitable and flexible contingencies are in place to minimise the impact of winter pressures to both staff and service users. Care UK has strategies in place to ensure that the appropriate levels of patient care are in place during pandemic, particularly in relation to flu. Care UK has a Winter and Escalation Plan that includes an escalation plan to mitigate changes in demand.

GP Out of Hours Service

Care UK has reviewed its workforce profiling and this will be higher than last year to cover expected increases in demand over the bank holiday weekends. They also have additional doctors on standby over this period that can be called on to give extra cover. Care UK has an escalation plan within their winter plan.

Walk in Centre

The Walk in Centre will be operating as normal. Last year the WIC had to close on a number of occasions due to volume of patients. Care UK has reconfigured the service so that it is more responsive to fluctuations in patient flow.

Previous problems with space in reception for patients have been addressed with the provision of an additional temporary waiting area for overspill patients. The WIC has introduced an appointments system for patients during periods of peak demand. This will reduce the likelihood of closure by spreading demand and reducing waiting area volumes.

The WIC will monitor call volumes and dispositions on a daily basis during the winter period. They will submit daily reports on total call activity, percentage triaged, face to face contacts and number of home visits. Care UK will monitor daily and weekly activity at the WIC and adjust workforce capacity to respond to predicted demand. For example if face to face activity increases and triage reduced, clinicians will be re-deployed to deliver more face to face support.

Rotas for call centre staff, drivers, receptionists and clinicians will be released 6 weeks in advance and continually managed to adjust workforce to meet both a rise and fall in activity and demand. If activity is higher than predicted then additional sessions or redeployment of resource will be implemented. Bank holiday staffing is based on previous year's activity, combined with recent trend analysis.

Last year one of the reasons for build up in the waiting area of the WIC was the relatively low turnover of patients at peak times. This year Care UK has introduced activity targets, which if achieved will reduce the likelihood of WIC closures this winter.

- Calls answered 12 calls per hour
- Triage GP calls answered 8 calls per hour
- Home Visiting GP 1 patient per hour
- WIC GP appointments 1 GP seeing 6 patients per hour
- WIC Nurse Practitioner appointments 1 NP seeing 4 patients per hour

Winter Single Point of Contact

Care UK has worked closely with commissioners to introduce a Winter Single Point of Contact. This pilot project aims to reduce demand for A&E and WIC services by triaging patients and providing appropriate self-help advice. The

Single Point of Contact is available 24 hours a day, 7 days a week from 1 October 2011 to 31 March 2012. It responds an urgent healthcare needs when:

- you need medical help fast, but it's not a 999 emergency
- you don't know who to call for medical help or you don't have a GP to call
- you think you need to go to A&E or another NHS urgent care service
- you require health information or reassurance about what to do next

The Single Point of Contact operates in accordance with the core principles set out in the national NHS 111 service specification:

- Completion of a clinical assessment on the first call without the need for a call back
- Ability to refer callers to other providers without the caller being re-triaged
- Ability to dispatch an ambulance without delay

Calls are answered by trained advisers, supported by nurse advisers and GPs, who assesses the caller's needs and determine the most appropriate course of action. Callers who can self care will have information, advice and reassurance provided. Those requiring further care or advice will be referred to a service that has the appropriate skills and resources to meet their needs. Callers facing an emergency will have an ambulance despatched without delay

The Single Point of Contact will provide management information to commissioners regarding the demand for and usage of services in order to enable the commissioning of more effective and productive service.

6.7 NHS DIRECT

NHS Direct have provided an overview of the arrangements put in place to meet the predicted increase in demand over the winter period 2011/12. The following mitigation activity has been put in place to manage fluctuations in demand.

Increasing the use of temporary staff – NHS Direct are continuing to work with agencies to provide flexible capacity for health and nurse advisors. The staff are fully trained by NHS Direct and can be quickly mobilised to deal with peaks in demand.

Maximising existing capacity – NHS Direct are offering additional pay incentives to encourage staff to take on additional hours and swap shifts. We have also increased the number of nurse advisors who can work from home either permanently or for short periods at peak times, and we are postponing all non-essential "off-line" activities.

Encouraging patients to go 'web-first' – NHS Direct have a suite of 40 online health and symptom checkers, which aim to shift telephone traffic onto the web. The online health and symptom checkers enable some patients to care for themselves without seeking telephone advice, and enable a shorter conversation with a nurse for those that do need additional advice on the phone via the 'click-to-call back' service.

Encouraging patients to contact us at less busy times – NHS Direct uses the telephone messaging and website to signpost callers with non-urgent enquiries to call in the daytimes, Monday to Friday**.**

6.8 YORKSHIRE AMBULANCE SERVICE

The Yorkshire Ambulance Service Winter Plan addresses the following key priorities;

- Protect and maintain operational performance plans in line with agreed performance trajectories for patient critical services
- Reduce hospital admissions through non conveyance and use of alternative pathways
- Ensure no patient, member of the public or member of YAS staff is put at risk
- Maintain optimum resource levels for critical clinical services
- Work with NHS partners to manage any demand increases effectively and efficiently.
- Invoke major incident plan and business continuity plans to maintain service delivery.
- Maximise fleet availability for frontline services and supply chain for critical services

Figure 2 sets out the key threats and risk is derived from the Yorkshire and Humber Regional Risk Assessment and information and intelligence available relating to long range weather forecasts and information on grit stocks.

Based on this risk assessment YAS's working strategy is to;

- Maximise resource capacity and capability over the period 1October 2011 to 31 March 2012
- Minimise the risks to staff safety through working time directive, occupational health support
- Monitor internal and external environments to anticipate any changes that have the potential to impact on operational activity
- Ensure all critical services business continuity plans have been reviewed and are fit for purpose
- Maximise resilience against the impact on our resource capacity from seasonal flu by increasing our staff uptake of seasonal flu vaccine
- Enact existing resilience plans when appropriate to do so e.g. Adverse Weather, REAP, Major Incident Plan.
- Maximise communications opportunities with staff, public and partner organisations
- Establish co-location at Ambulance HQ with SHA Emergency Preparedness Team to mitigate impact of changes within the NHS Structures.

Figure 2: Key threats and risks to YAS derived from the Yorkshire and Humber Regional Risk Assessment					
ID	**Threat**	**Likelihood**	**Impact**	**Risk**	**Direct impact – Department**
1	999 activity and GP OOH activity will be on or above trajectory for the period of the plan and impact on delivery of 8 minute standard.	Probable	Significant	High	A&E, A&R,GPOOH
2	Staff non – attendance levels will increase	Probable	Significant	High	All Departments
3	Hospital Turnaround Times will increase at key hospitals	Probable	Significant	High	A&E
4	Severe weather e.g Snow, Freezing temperatures, Floods, Gales etc. will impact on the service periodically over the period.	Probable	Significant	High	All Departments
5	New NHS re-organisations impacts on coordination and communications	Possible	Moderate	Medium	All Departments
6	The lack of availability of grit and gritting of key routes for ambulance access	Possible	Significant	Medium	A&E, PTS
7	Staff welfare will be compromised at times over the period due to high demand, overtime commitments, increased stress levels	Probable	Moderate	High	A&E, A&R, GPOOH, PTS
8	Major Incident(s) could occur at some point of the period	Possible	Significant	High	A&E, A&R, PTS
9	Industrial Action of Public Sector workers inc. Ambulance Service Staff	Probable	Significant	High	Specific plan in place

6.9 PATIENT TRANSPORT

PTS have a clear understanding of daily activity levels for both routine and essential journeys. During periods of bad weather all reasonable plans will be implemented to deliver a business as usual service. If the disruption is severe and prolonged YAS will isolate and prioritise essential and urgent journeys which are estimated to be 990 journeys per day of which approximately 100 are awkward. These journey's will be agreed with the relevant acute trust. Additional 4x4 capacity will be deployed in Rotherham. YAS can respond and provide a flexible discharge service whereby ambulances can be diverted away from non essential PTS journey to clear bed capacity at RFT. The winter weather watch risk assessment will take into account local road conditions and inform PTS commissioners whether it is safe to undertake business as usual or only essential journey's . All PTS crews will be despatched double handed where there is a risk of not being able to fully access a property. The PTS BC plan has been reviewed and revised in September 2011 taking in lessons learnt from Exercise Starling (Winter 2010/11).

6.10 RDASH – MENTAL HEALTH AND LEARNING DISABILITIES

RDaSH will continue to operate services as normal over the winter period and they do not anticipate any additional pressures with increased demand for services over the winter period. They will initiate their business continuity plans in the event of severe weather. The Mental Health Crisis Intervention Team will continue to work the bank holiday period with the team supporting A&E as they do out of hours. RDaSH is aiming to increase uptake of staff flu vaccination from last year. They are also having discussions with TRFT to look at providing in-reach services for patients with mental health problems to expedite discharges.

6.11 CHILDREN'S SERVICES

Children's community services following April 2011 include The complex Care team, Health Visiting, School nursing, Children's Development Centre and Children's therapy teams. Business continuity plans are in place for winter pressures and these include up to date contact details for all staff employed. RAG rated plans are used to ensure essential work continues should we business continuity plans need to be instigated. The main areas of concern for the service would be inclement weather and high levels of sickness

Children's acute services form part of TRFT's winter plan. This includes guidance for management of acute bed shortages on the children's ward and has an escalation process for both bed shortages and concerns around nursing/medical staff shortages.

7. FLU IMMUNISATION PROGRAMME

Potential impact for flu is expected to be the same this year as for last year. All front-line NHS and RMBC employees whose role involves patient contact with the service users will be offered immunisations. Drop in sessions have been made available in various locations. Maternity services have agreed to vaccinate pregnant women during ante natal checks and children's services are included in the vaccination programme.

Work is ongoing with bereavement services and the crematoria in the event of an increase in activity. Processes have been put in place for this to be flagged with the crematoria and agreement has been made to relax paperwork where possible.

8. WINTER COMMUNICATIONS PLAN

NHSR's communication plan for winter 2011/12 aims to give a fresh push to support a number of interrelated projects to encourage members of the public to seek the most appropriate urgent care according to their needs and in line with the current Choose Well framework.

The projects are;

- The new telephone number (SPC number) for patients to ring BEFORE they travel to A&E or the walk in centre which will eventually be replaced by the national 111 number. This will require an intensive campaign over the winter period.
- A more targeted approach to specific groups about A&E usage including those attending the department
- Enhanced and localised Choose Well materials for Rotherham population.

Therefore there are three distinct audiences;

1. Patients who are already in A&E or the Walk in Centre
2. Patients who are considering attending A&E or the WIC
3. General public

Aim

1. To reduce the number of A&E/WIC attendances

Objectives

1. Raise awareness of alternatives to A&E/WIC
2. To promote the new SPC number
3. To raise awareness of the acute work of the A&E department.

This will be done through a variety of media including leaflets, posters, facebook, twitter, radio and the local press. Further work will be done in liaison with TRFT to develop digital signage at the main hospital entrance to communicate waiting times, bedside TV videos and messages, and live waiting time feeds in waiting areas.

A regional bid has been made to the Warm Homes, Healthy People fund to develop a communications resource and strategy. This will ensure a consistent message is given to the public and staff. Further work will be done to develop and complete this strategy by April 2012.

9. THE NHS COLD WEATHER PLAN FOR ENGLAND – ROTHERHAM

NHS Rotherham has adopted the Cold Weather Alert System set out in the NHS Cold Weather Plan for England. The NHS Cold Weather Plan includes four alert levels, which are issued by the Met Office on the basis of either of two measures: low temperatures or widespread ice/heavy snow. Please note that the Cold Weather Plan for England was published in November 2011 and information given in the plan regarding how Rotherham is adopting this plan will require further development through joint work across the local health and social care community.

9.1 LEVEL 1: WINTER PREPAREDNESS – LONG TERM PLANNING/GENERAL PREPARATION

Level 1 includes long-term strategic planning activities that can take place throughout the year. It includes general winter preparedness, running alongside seasonal activities such as annual flu vaccination programme.

Responsibilities at Level 1

The following personnel will receive the Met Office cold weather alerts either directly from the Met Office or via their Emergency Planning Managers, SHA or Government Office and disseminate throughout their organisation to the most appropriate personnel.

The officers listed below will either action or instruct others to action the points as detailed for Level 1.

- NHS Rotherham Directors on Call
- NHS Rotherham Emergency Planning Manager
- NHS Rotherham Medicines Management Team
- The Rotherham Foundation Trust Corporate Lead for Business Resilience and Emergency Planning/Quality and Standards Manager/Group Nurse.
- Rotherham Community Health Services Directors on call
- NHS Rotherham Head of Communications
- RDaSH Emergency Planning Manager
- Rotherham Metropolitan Borough Council (RMBC) Emergency and Safety Team
- RMBC Neighbourhood and Adult Services
- RMBC Children and Young People's Service
- Care UK (Walk in Centre and GP OOHs)
- Yorkshire Ambulance Service
- PTS providers.

This level is in force throughout the winter from 1 November to 31 March and covers the activity that should take place to prepare for winter pressures. The Emergency Care network has been working with partners improve winter resilience. Rotherham MBC and Public Health are delivering a co-ordinated programme to support improved housing, heating and insulation. All partner organisations have flu vaccination programmes in place for staff working on frontline services. Finally multi-agency plans are in place to respond to surges in demand and frontline staff have started to identify those most at risk.

Alert trigger	Health, social care and local authorities	Community and voluntary sector	Individuals	Communications
This plan will require further development with partner organisations				
Level 1 **Long-term planning** *(all year)*	**Organisations and professional staff work with partner agency staff** • *Develop a shared understanding of excess winter deaths and what partners can do to reduce them* – Rotherham Affordable Warmth Strategy is currently in development. Application to Warm Homes Healthy People Fund for Rotherham to reduce Excessive Winter Death numbers during winter 2011/12. • *Identify those at risk from seasonal variations* – a list of examples of at risk groups is attached at Appendix 1. • *Improve winter resilience for those at risk.* • *Ensure that a local, joined-up programme is in place to support improved housing, heating and insulation* - Rotherham Affordable Warmth Strategy is currently in development. • *Assess responses to climate change issues – a reduction in carbon emissions and preparing for the expected health impacts* - Rotherham Affordable Warmth Strategy is currently in development.	• *Develop a community action plan*- Community organisations will be involved in the development of the Rotherham Affordable Warmth Strategy. NHSR is working with Age Concern to develop a community action plan for older people.	• *Insulate your home and protect water pipes from freezing* • *Check your entitlements t benefits and local grants* Patients will be encouraged to follow advice as identified in Keep Warm Keep Well campaign.	NHSR has set up a section on the NHSR website relating to winter health. This includes: Keep Warm Keep Well Affordable Warmth Hot Spots The information is aimed at practitioners and the public. A regional bid has been made to the Warm Homes, Healthy People fund to develop a communications resource and strategy. This will ensure a consistent message is given to the public and staff. Further work will be done to develop and complete this strategy by April 2012.
Winter preparedness programme *(1 November – 31 March)*	**Organisations** • *Work with partner agencies to co-ordinate cold-weather plans* – The Rotherham Emergency Care Network is made up of representatives from partner agencies who	• *Develop a community action plan*	• *Find good information about health risks* • *Check your entitlements and benefits* • *Get a flu jab if you are in a*	Communications plan to support projects to encourage members of the public to seek the most appropriate urgent care according to their needs

Alert trigger	Health, social care and local authorities	Community and voluntary sector	Individuals	Communications
This plan will require further development with partner organisations				
	work together to share plans and to improve winter resilience. **See 3. Leadership and co-ordination of winter planning.** • *Work with partners on risk reduction awareness (eg flu jabs for staff), information and education* – annual campaign by NHS Rotherham and partner organisations to encourage uptake of flu jabs for both staff and for the public identified as 'at risk'. • *Plan for winter surge in demand for services* – The following organisations have Winter Plans in place to cope with a surge in demand for services and these have been shared through the Emergency Care Network: ▪ The Rotherham Foundation Trust Winter Plan 2011/12 (includes community services) **See 6.2 and 6.3 Rotherham Foundation Trust.** ▪ The Rotherham Surge and Rapid Discharge Plan **See 6.1 NHS Rotherham** ▪ Care UK (Walk in Centre and GP OOHs) **See 6.6 Care UK – Urgent Care Services.** ▪ NHS Direct **See 6.7 NHS Direct** ▪ Yorkshire Ambulance Service **See 6.8 Yorkshire Ambulance Service** ▪ RDaSH (business continuity plan) **See 6.9 RDaSH.** ▪ There are plans to reconfigure community services and some social care services for winter resilience –		*risk group* • *Insulate your home and protect water pipes from freezing* • *Look out for vulnerable neighbours*	and in line with the current Choose Well framework. **See 8. Winter Communications Plan.**

Alert trigger	Health, social care and local authorities	Community and voluntary sector	Individuals	Communications
This plan will require further development with partner organisations				
	Alternative Levels of Care, Virtual Ward, GPs in A&E, Winter Single Point of Contact and realignment of Intermediate Care. **See 6.3 Rotherham FT – Community Services and 6.4 Rotherham MBC – Adult Social Care Services.** **Professional Staff** • *Identify those at risk on your caseload* – staff will be asked to consider how they will identify patients who are considered at risk. In Rotherham the key vulnerable groups will be: ▪ Patients who require renal dialysis ▪ Patients undergoing cancer treatment ▪ Patients who are currently on a community matron or district nurse caseload. ▪ Patients known to Breathing Space. ▪ Patients in the community on a 'virtual ward.			

9.2 LEVEL 2: ALERT AND READINESS

Level 2 is declared when the Met Office forecasts a 60% risk of severe winter weather in one or more defined geographical area in the days that follow. This usually occurs two to three days ahead of the event. A Level 2 alert will be issued when a mean temperature of 2°C is predicted for at least 48 hours, with 60% confidence, and/or widespread ice and heavy snow is forecast, with the same confidence.

Responsibilities at Level 2

The following personnel will receive the Met Office cold weather alerts either directly from the Met Office or via their Emergency Planning Managers, SHA or Government Office and disseminate throughout their organisation to the most appropriate personnel.

The officers listed below will be responsible for dissemination or action:

- NHS Rotherham Directors on Call
- NHS Rotherham Emergency Planning Manager
- NHS Rotherham Medicines Management Team
- The Rotherham Foundation Trust Corporate Lead for Business Resilience and Emergency Planning/Quality and Standards Manager/Group Nurse.
- Rotherham Community Health Services Directors on call
- NHS Rotherham Head of Communications
- RDaSH Emergency Planning Manager
- Rotherham Metropolitan Borough Council (RMBC) Emergency and Safety Team
- RMBC Neighbourhood and Adult Services
- RMBC Children and Young People's Service
- Care UK (Walk in Centre and GP OOHs)
- Yorkshire Ambulance Service
- PTS providers.

Local health community organisations will be required to communicate alerts to staff and make sure that they are aware winter planning arrangements. NHS Rotherham will send out appropriate media messages to raise awareness on what actions the public should take. Professional staff will have identified those most at risk and be preparing service response to those patients.

Alert trigger	Health, social care and local authorities	Community and voluntary sector	Individuals	Communications
This plan will require further development with partner organisations				
Level 2 Alert and Readiness *60% risk of severe cold in the following days*	**Organisations** • *Communicate public media messages.* • *Communicate alerts to staff and make sure that they are aware of winter plans* – ensure CRIP reports (includes Met Office Alert) are forwarded to relevant organisations. • *Implement business continuity* – all partner organisations to initiate the appropriate stage of their business continuity plans and winter plans. Staff to be on alert. **Professional staff** • *Identify those most at risk* – community nursing teams to identify and prioritise patients on their current caseload. Renal and cancer patients requiring transport for treatment to be identified and procedure followed for snow clearance. Key vulnerable groups as identified by NHS Rotherham are set out under Level 1. • *Check client's room temperature if visiting* – all health and social care staff working in the community.	• *Keep an eye on people you know to be at risk.* NHSR is working with Age Concern to develop a community action plan for older people.	• *Stay tuned into the weather forecast and keep yourself stocked with food and medications.* • *Check ambient room temperatures.* • *Make sure that you get any benefits to which you are entitled.*	Public health information is available on the internet through the 'Live Well' website and the 'Winter Watch' website. A section is available on NHSR's webpage with information for staff and patients to keep up to date with developments. A regional bid has been made to the Warm Homes, Healthy People fund to develop a communications resource and strategy. This will ensure a consistent message is given to the public and staff. Further work will be done to develop and complete this strategy by April 2012.

9.3 LEVEL 3: SEVERE WEATHER ACTION

A Level 3 alert is issued when the weather described in Level 2 above actually happens. It indicates that severe winter weather is now occurring, and is expected to impact on people's health and on health services.

Responsibilities at Level 3

The NHS Rotherham Director on call/Director of Public Health and the NHS Rotherham Emergency Planning Manager working with other health partners listed above at Alert Level 1 and Level 2 plus Rotherham Metropolitan Borough Council will:

Alert trigger	Health, social care and local authorities	Community and voluntary sector	Individuals	Communications
This plan will require further development with partner organisations				
Level 3 Severe weather action	**Organisations** • *Activate plans to deal with a surge in demand for services.* All partner organisations to initiate/continue the appropriate stage of their business continuity/winter plans. Consider initiation of Surge and Rapid Discharge Plan. **See 6.1 NHS Rotherham.** • *Mobilise community and voluntary support.* Support will be requested from voluntary groups as outlined in TRFT's Plan for Severe Adverse Weather (Snow). **See 6.2 and 6.3 Rotherham Foundation Trust.** To provide first aid, routine welfare support, transport, rescue and emotional support. Voluntary groups will also be mobilised to assist with snow/ice clearance from driveways of patients attending for renal dialysis. • *As appropriate, contact those at risk (visit, phone call) daily.* Community nurses to contact patients on their current workload. Breathing Space to contact patients considered 'at risk'. Community staff to contact patients on 'virtual wards'. PTS to contact patients needing transport for renal dialysis and cancer treatments. • *Communicate public media messages.* • *Ensure staff can help and advise clients.* Ensure staff are aware of cold weather health risks and are able to advise clients how to protect against them, including	• *Activate community action plan* – this will include volunteers to clear driveways/paths for renal patients. NHSR is working with Age Concern to develop a community action plan for older people.	• *Clear pavements.* • *Set daytime room temperature to 21° C* • *Set bedroom night-time temperature to at least 18°C* • *Dress warmly, eat well* • *Check those you know are at risk.*	A section is available on NHSR's webpage with information for staff and patients to keep up to date with developments. A regional bid has been made to the Warm Homes, Healthy People fund to develop a communications resource and strategy. This will ensure a consistent message is given to the public and staff. Further work will be done to develop and complete this strategy by April 2012.

Alert trigger	Health, social care and local authorities	Community and voluntary sector	Individuals	Communications
This plan will require further development with partner organisations				
	hospitals, care, residential and nursing homes. The Renal Unit will liaise with patients to identify patients at risk of not being able to attend for dialysis. **Professional staff** • *Signpost clients to appropriate benefits.* • *Maintain business continuity.*			

9.4 LEVEL 4: MAJOR INCIDENT

A Level 4 alert indicates that many parts of the country are experiencing exceptionally severe winter weather and the conditions are affecting critical services. Such weather conditions are likely to have significant impacts not only on health, but also on other sectors and critical infrastructure. A cross-governmental response may be required, however, some actions can be taken by the health sector.

Health and social care services will ensure that Level 3 actions continue during the emergency period. Measures will be taken to ensure that local healthcare providers that are most vulnerable to extreme winter conditions can continue to operate, for example adequate clearing of snow and gritting to ensure safe emergency access. During extreme conditions, it is not only high-risk groups that may be at risk. Therefore further risk appraisals will be made as to how the wider population is likely to be affected. The Department for Communities and Local Government's Resilience and Emergencies Division will support the co-ordination of a cross-sector response to the period of extreme winter weather. In the event of a major incident being declared, all existing emergency plans and procedures will apply and NHS Rotherham will activate its Emergency Plan and Emergency Management Arrangements to set up the incident room/ emergency centre.

Alert trigger	Health, social care and local authorities	Community and voluntary sector	Individuals	Communications
This plan will require further development with partner organisations				
Level 4 Emergency Response Exceptionally severe weather or threshold temperatures breached >6 days	Level 4 alert declared by central government Response likely to involve: • National government departments • Executive agencies • Public sector, including health sector • Voluntary sector At all levels		NATIONAL EMERGENCY ACTION Multi-agency response required and co-ordinated by central government Response by Health: • Activiate major incident plan. • Consider setting up an emergency centre. • Condiser setting up a help line if appropriate. • Liaise with TRFT re mortuary capacity. • Be aware that reception centres may be set up. • If not already done, activate business continuity plans for commissioner and contractors. • Set up a multi-agency meeting chaired either by the Local Authority or the police. • A silver meeting with NHSR should be convened to assess the situation with a reporting structure from GPs, pharmacists, TRFT, GP out of hours and mental health services re staff, resources, caseload and travel. • Liaise with the Local Authority regarding vulnerable groups. • Lists of renal and cancer patients requiring assistance with snow/ice clearance to enable them to attend for treatment will be sent to the gritting department/voluntary groups (process currently being agreed). • Consider fuel supplies, heating and lighting, travel and staff rotas and workforce analysis. • Liaise with council regarding road clearance and safe routes. Also to consider: • Livestock food and milk supplies. • School closures. • Water shortage re burst/frozen water pipes.	

APPENDIX 1 – AT RISK GROUPS

Over 75 years old
Frail
Pre-existing cardiovascular or respiratory illnesses and other chronic medical conditions
Renal and cancer patients undergoing treatment
Severe mental illness
Dementia
Learning difficulties
Arthritis, limited mobility or otherwise at risk of falls
Young children
Living in deprived circumstances
Living in homes with mould
Fuel poor (needing to spend 10% or more of household income on heating home)
Elderly people living on their own
Homeless or people sleeping rough
Other marginalised groups

REPORT TO HEALTH AND WELLBEING BOARD

1.	**Meeting:**	**Health and Wellbeing Board**
2.	**Date:**	**18th January 2012**
3.	**Title:**	**Children and Young People's Plan 2010-2013 Progress Report**
4.	**Directorate:**	**RMBC – Children and Young People's Services**

5. Summary

In July 2010 The Children's Trust Board published a new Children and Young People's Plan (CYPP); this sets the strategic priorities for the work of partners on the Children's Trust Board and provides the framework for commissioning decisions.

The Children and Young People's Board has also chosen nine areas of focus for priority action. Six action plans were published to accompany the Children and Young People's Plan. The Children and Young People's Trust Board has recently reviewed these action plans and they will be disestablished in the light of changed statutory requirements and the need for more streamlined working practice across the children and young people's partnership.

This report provides a progress update on activities identified in the CYPP and advises the Board of how activity will be managed in the future.

6. Recommendations

The Health and Wellbeing Board is asked to:

- Note the progress made against the key areas of focus identified in the Children and Young People's Plan;
- Ensure that the Health and Wellbeing Strategy is aligned with the Children and Young People's Plan;
- Note the governance arrangements, in particular for the areas of focus most closely linked to the health and wellbeing agenda: giving babies the best start in life, obesity and alcohol.

7. Proposals and Details

Background

The statutory requirement for a Children's Trust Board and a Children and Young People's Plan has been revoked by the coalition government. However, in Rotherham, the Children's Trust Board remains committed to providing a strong leadership role for integrated children's services, and has concluded that the Children and Young People's Plan provides an invaluable planning framework to guide strategic and operational decision-making across the partnership. The Children and Young People's Plan also provides the framework for commissioning decisions.

The CYPP identifies 'four big things' that will be central to business of the Children and Young People's Partnership; these are 'keeping children and young people safe' 'prevention and early intervention', 'tackling inequalities' and 'transforming Rotherham learning'.

Areas of Focus

Seven areas of focus were identified in the CYPP 2010-2103. The purpose of this focus is to draw attention to areas which were felt to need additional forensic attention, significant investment or change management in order to alter the direction of travel or significantly accelerate along a chosen path.

(i) Areas of Focus and the CYPTB Commissioning Plan
The CYPTB Executive Group undertook further work in June 2011 to identify the priority areas that would most benefit from partnership working by Board members.

The four main priority areas agreed by the group are:

- Children get the best start in life which includes implementing the early prevention agenda and reducing health inequalities including tackling obesity.
- Reducing substance misuse by young people, specifically in relation to alcohol.
- Children and young people affected by domestic abuse are supported and protected.
- To ensure all Rotherham schools are performing well, especially in relation to Key Stage 2.

The CYPTB Commissioning Plan will respond to these identified priority areas. The Commissioning Team have already commenced a needs analysis, a summary of which is provided for this report

(a) Giving babies a healthy start / Obesity (children get the best start in life)

This priority covers a number of key health priorities including infant mortality, reducing health inequalities, obesity and the effective delivery of early help to vulnerable families with young children.

Rates of breastfeeding have improved (both initiation and prevalence at 6-8 weeks) and are now in line with neighbouring boroughs. However rates are still below both Yorkshire and Humber and England averages.

Obesity remains high; 35% of children in Rotherham are classified as overweight or obese. 1 in 4 children in reception and 1 in 3 children in Year 6 are overweight or obese.

Partners involved in work to give babies a healthy start include Rotherham Foundation Trust, NHS Rotherham, GPs and RMBC Children's Centres and other early years providers. Weight management intervention programmes are commissioned through a number of providers including Carnegie Weight Management, DC Leisure and Clifton Medical Proactice. In addition, partners who are delivering prevention and treatment are Rotherham Foundations Trust, NHS Rotherham, GPs, Children's Centres and GPs.

The Prevention & Early Intervention Strategy is currently being refreshed, under direction from the Think Family Board. The new 'Early Help Strategy' will be

launched in April 2012, together with plans to ensure it is operationally deliverable. These plans will include successful programmes of support such as the Family Nurse Partnership.

(b) The problems caused by alcohol (reducing substance misuse by young people)

728 children have parents who are receiving structured treatment for drug and alcohol issues, 241 of these children are under 5; 90% of these children are not receiving additional support and work is underway to address this.

In 2010/11 134 young people received structured treatment. However the 2011 Lifestyle Survey indicates that the problem is much larger than this figure would indicate. In 2011 the number of young people drinking 1-10 units per week increased to 70%. 43% of children and young people said that they obtained alcohol from their family.

This work is led by the Safer Rotherham Partnership which has links to the Think Family Board. Partners involved include NHS Rotherham, RDASH, RMBC, South Yorkshire Police and Colleges.

A new screening tool has been developed for use by all partner agencies. It is hoped that this will reduce pressure on specialist agencies. To address the issue of the high numbers of children and young people with substance misusing parents who do not receive additional support a temporary post within Drug and Alcohol Services has been created. The Healthy Schools Programme and South Yorkshire Police both continue to deliver programmes in schools to raise awareness of the problems caused by drugs and alcohol; however, funding for these programmes is under threat.

(c) Domestic abuse (children & young people affected by domestic abuse are supported and protected)

Domestic Abuse continues to be a significant feature of referrals to the local authority's children's access and assessment team. Contacts for a 12 month period beginning on 1st April 2010 were 1799 children, 665 progressed to referrals or re-referrals for services. Contacts between 1st April 2011 and 19th October 2011 for new cases concerning domestic abuses was already 1454 children of whom 396 had been referred.

In 2011/12, up until the end of September, 180 cases were referred to IDVA, 144 had been referred to MARAC of which 89 were families with 173 children involved.

The Borough Wide Local Authority Contact and Assessment Team for Children's Services will continue to work with South Yorkshire Police and IDVAs to pilot a triage process for children and young people affected by domestic abuse and these arrangements will be captured in the operational delivery plans for the refreshed Early Help Strategy.

The Safer Rotherham Partnership steers the work of the Rotherham domestic abuse sector through the Domestic Abuse Priority Group. In addition, the Rotherham Local

Safeguarding Children's Board and the Safeguarding Adults Board are aligning their roles to ensure effective scrutiny and challenge of the domestic abuse sector.

(d) Communication, language & learning (schools performing well / KS2)

The overall performance for Key Stage 2 in 2011 was above the government floor target which is that 60% of pupils should achieve Level 4 or above in both maths and English. The Rotherham performance was 69%, an improvement of 2.5% since 2010.

However, there remain 14 schools who are not reaching the floor target.

The work to improve performance is being led by the Rotherham School Improvement Partnership which is working with the Rotherham Teaching School Alliance to put in place a network of peer support and challenge. This will be funded through the Dedicated Schools Grant.

The Department for Education have validated the Rotherham approach. The School Improvement Partnership will continue to lead for this priority area and provide progress reports to the Children and Young People's Trust Board.

(ii) Areas of Focus not in the CYPTB Commissioning Plan

The Areas of Focus that fall outside these priorities are looked after children, understanding and responding to the needs of migrant communities, 14-19 and post-16 opportunities for young people with learning difficulties and disabilities.

(a) 14-19

The CYPTB received a detailed report on this area of focus on 27th July 2011. Some of the activities identified in the CYPP are no longer relevant since the statutory requirement to have a 14-19 Plan and a 14-19 Strategy Group have been removed.

Rotherham has in place a Raising Participation Age (RPA) Plan, which has been developed by the RPA Strategy Group. The RPA Strategy group will also be responsible for overseeing its implementation. The group will report to the Economy Board, Health and Well-Being Board and the Children and Young People's Trust Board, via RMBC's CYPS Directorate Leadership Team. The plan will support Rotherham's 11-18 provider network (i.e. Academies, Further Education Colleges, Maintained Schools, Sixth Form College and Work-Based Learning organisations) and other partners in their planning and delivery of education and training to Rotherham's young people.

(b) Looked After Children

Two of the key objectives identified in the CYPP for this area of focus have been achieved; The Looked After Children's Service (LAC Service) was established in October 2010. The central focus of the team's work is to improve outcomes for children and young person who are looked after by the local authority. The overall welfare of the child, including their welfare in education, will guide all practice. The LAC Service Manager report to the Director of Safeguarding and Corporate

Parenting and is accountable to Rotherham's Corporate Parenting Board. The Corporate Parenting Board has its inaugural meeting in March 2011. The Board is chaired by Cllr Paul Lakin, thus providing a direct link with the CYPTB.

(c) Post-16 Opportunities for Young People with Learning Difficulties and Disabilities

Progress continues to be made for all the key activities identified in the CYPP, however, there remain significant costs associated to out of area provision for young people with LDD. Work is currently underway with partners to explore provision options in the Borough that would meet learning needs, be more cost effective and utilises social care budgets accordingly.

The behaviour collaboratives are established and developing provision with a particular focus on reducing the number of young people who need to be moved out of authority.

The work is overseen by the Rotherham School Improvement Partnership.

(d) Understanding and responding to the needs of migrant communities

A Strategic Lead has been appointed for Early Intervention and New Arrivals; this appointment will ensure that CYPS is able to contribute to (and in some cases lead) the work of the Local Strategic Partnership to respond to the needs of the Roma community.

Action Plans

It has been proposed that the aspirations identified in each of the six action plans are formally assigned to sub-groups of the Children and Young People's Trust Board and other partnership structures including the Think Family Board and the Rotherham Local Safeguarding Children Board. Work is currently underway to ensure that governance arrangements are clarified and simplified. The Children and Young People's Trust Board has requested a further report in February 2012.

8. **Finance**

The CYPP 2010-2013 and any associated documents must provide clarity to influence the allocation of resources undertaken by the CYPTB, in partnership and by each organisation represented.

9. **Risks and Uncertainties**

If plans and strategies are not clearly aligned there is a risk of duplication and lack of proper accountability.

10. **Policy and Performance Agenda Implications**

The Children and Young People's Plan should be aligned with other key plans for the local authority and partners:
Health & Wellbeing Strategy

RMBC Corporate Plan
RLSCB Business Plan
Economic Plan

11. **Equality and Diversity**

An Equality Impact Assessment has been completed for the CYPP 2010-2013; the recommendations in this report do not have an impact on the validity of this process.

12. **Background Papers and Consultation**

CYPP 2010-2013

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the voice of NHS leadership

NHS CONFEDERATION

The Operating Framework for the NHS 2012/13
November 2011

On 24 November 2011 the Department of Health (DH) published the Operating Framework for the NHS in England for 2012/13, the first full year of the transition to the proposed new structure for the NHS.

We believe its focus will help the NHS shift into implementation mode and away from the political debate, and we are pleased it does not contain lots of new initiatives.

This briefing outlines the key points from the Operating Framework and what we see as the challenges and opportunities for members.

Key announcements in the Operating Framework include:

- key areas for improvement of dementia and care of older people, carers support, and military and veterans health
- a range of outcome measures or proxies for them under the domains of the NHS Outcomes Framework
- new measure for referral to treatment so that 92 per cent of patients on an incomplete pathway should have been waiting no more than 18 weeks
- PCT clusters to ensure all patients are seen on the basis of clinical need with no justification for the use of minimum waits
- the running cost of clinical commissioning groups (CCGs) to be £25 per head
- all NHS trusts expected to achieve NHS foundation trust (FT) status by April 2014 other than by exceptional agreement
- PCT allocations to grow by at least 2.5 per cent
- tariff price adjuster will be a reduction of at least 1.5 per cent. This will also be applied to non-tariff services
- CQUIN (Commission for Quality and Innovation) to be increased to 2.5 per cent on top of actual 'outturn' value.

OPERATING FRAMEWORK OVERVIEW

Sir David Nicholson's introduction emphasises the importance of getting the basics right, in light of recent Care Quality Commission and Health Service Ombudsman reports, alongside the importance of maintaining a grip on performance, meeting the QIPP (Quality, Innovation, Productivity and Prevention) challenge and building the new system.

The Framework for 2012/13 is set out in four chapters that cover: quality; reform; finance and business rules; and planning and accountability.

Its stated goals are to improve services for patients by:

- putting patients at the centre of decision making
- successfully completing the last year of transition to the new system and building CCG capacity
- increasing the pace of delivery of the quality and productivity (QIPP) challenge
- maintaining strong control over service and financial performance.

QUALITY

Improving services and patient experiences

- the staff survey results should be monitored locally and nationally
- all NHS organisations must comply with the Equality Act 2010 and its associated Public Sector Equality Duty
- the NHS needs to be ready in 2012 with clinical governance arrangements for medical revalidation
- NHS bodies must ensure staff have knowledge of English necessary to perform their duties.

Dementia and care of older people

- the Operating Framework identifies a systemic set of areas that organisations need to work together on, including:
    - commissioners need to ensure providers comply with relevant NICE standards
    - commissioners should work with GPs to improve general practice and community services so that patients only go into hospital if that will secure the best clinical outcome.
    - organisations are to ensure information is published in providers' quality accounts including:
        - ensuring participation in and publication of national clinical audits for services for older people
        - reducing inappropriate prescribing of antipsychotic drugs for people with dementia
        - improving diagnosis rates
        - continuing to eliminate mixed-sex accommodation
        - use of inappropriate emergency admission rates as a performance measure
        - non-payment of emergency readmissions within 30 days of discharge following an elective admission.
- PCT clusters should ensure all providers have a systematic approach to improving dignity in care, staff training and incorporating learning from patients and carers.
- PCTs need to work with local authorities to set out progress on the national dementia strategy and local or national CQUIN goals should be included in 2012/13.

Carers

- PCT clusters to agree policies, plans and budgets with local authorities and voluntary groups to support carers where possible with personal budgets. Plans should be in line with the national carers strategy and published on PCT websites by 30 September 2012.

Military and veterans health

- SHAs to maintain and develop their armed forces networks to ensure principles of the Armed Forces Network Covenant are met.
- Implementation of the MoD/NHS Transition protocol for those seriously injured in the course of duty, as well as improving mental health services for veterans.

Health visitors and family nurse partnerships

- SHA and PCT clusters need to work together to increase the number of health visitors
- PCT clusters are to maintain existing delivery and expand family nurse partnerships to double capacity to 13,000 places by April 2015.

Outcomes across the domains of the framework

The Operating Framework makes significant reference to a range of measures in the NHS Outcomes Framework, which we have summarised below.

- NHS organisations are expected to prepare to use the NHS Outcomes Framework to hold the NHS Commissioning Board to account in 2013/14
- The Operating Framework identifies outcome measures or proxies for each of the domains of the Outcomes Framework which are set out below
- NHS organisations should continue to work to meet expectations in service specific outcomes strategies published for services such as mental health services, cancer and long-term conditions associated with premature mortality
- Each domain is to be underpinned by a suite of NICE quality standards.

Outcomes Framework Domain 1: preventing people from dying prematurely

- the NHS is to support clinical strategies aimed at reducing early mortality from cardiovascular disease, including heart disease, stroke, kidney disease and diabetes. Commissioners and providers need to work together to ensure earlier diagnosis and treatment
- all hospital trusts should examine and explain their Summary Hospital Mortality Indicator and identify and act where performance is falling short
- existing operational standards in ambulance services should continue to be met or exceeded
- all four of the 31 day operational standards and all three of the 62 day operational standards for early cancer treatment should continue to be met or exceeded.

Outcomes Framework Domain 2: enhancing quality of life for people with long-term conditions

- the NHS needs to track progress in improving quality of life for people with long-term conditions through indicators including the proportion of people feeling supported to manage their condition and unplanned hospitalisation for certain patients
- PCTs with local authorities and emerging CCGs should spread the benefits of telehealth and telecare
- PCTs should consider the *No Health Without Mental Health* strategy to support local commissioning, with a particular focus on: access to psychological therapies as part of the full roll-out by 2014/15 with an increase in access for black and minority ethnic groups, older people and people with severe mental illness and long term health problems; physical healthcare of those with mental illness; offender health; and targeted support for children and young people at particular risk, such as looked after children.
- NHS organisations need to meet the QIPP challenge with a continued focus on investment in high-quality mental health services, with national monitoring of:
    - number of new cases of psychosis served by early intervention teams
    - percentage of inpatient admissions gate-kept by crisis resolution/home treatment teams
    - proportion of people under adult mental illness specialities on the Care Programme Approach (CPA) who were followed up within seven days of discharge from inpatient care.

Outcomes Framework Domain 3: Helping people to recover from episodes of ill-health or following injury

- the Operating Framework makes clear that commissioners need not reimburse hospitals for admissions within 30 days of discharge following elective admission, but that savings are to be invested in clinically driven initiatives through reablement and post-discharge support. Commissioners are to work with partners to ensure initiatives are understood and used by patients
- the DH will monitor emergency admissions for acute conditions that do not normally require admission and seek confirmation on the deployment of savings.

Outcomes Framework Domain 4: Ensuring that people have a positive experience of care

- a Duty of Candour is being introduced – a new contractual requirement on providers to be open and transparent regarding mistakes
- commissioners are to ensure contracts allow for central returns on mistakes, 'never events', incidents and complaints, and use sanctions if providers are not compliant
- in addition to existing national surveys, each local organisation is expected to carry out more frequent patient surveys, including the use of real-time data, and to respond appropriately where needed
- commissioners need to identify local measures of integrated care that will support improved delivery such as patient-reported outcomes
- PCT clusters should publicise the NHS Constitution right for a maximum 18-week wait for treatment from referral for non-urgent conditions, as well as the options

available where there is a risk that treatment will not be provided within 18 weeks. It is the provider trust's responsibility to ensure patients have the information. Pilots focused on orthopaedics especially will be carried out in 2012/13 to indentify the best ways trusts can meet this responsibility

- the referral to treatment (RTT) operational standards of 90 per cent for admitted and 95 per cent for non-admitted completed waits remain. In order to sustain the delivery of these standards, trusts will need to ensure that 92 per cent of patients on an incomplete pathway should have been waiting no more than 18 weeks
- the RTT standards should be achieved in each speciality and will be monitored monthly. Less than 1 per cent of patients should wait longer than six weeks for a diagnostic test
- patients should have access to Choose and Book and commissioners should take all reasonable steps to offer the patient a quicker appointment at a range of alternative providers, if the patient makes such a request
- patients need to continue to be informed that the two week wait is standard from GP referral for urgent referrals where cancer is suspected and the standard for two week waits from GP referral for breast symptoms should be met
- PCT clusters must ensure all patients are seen on the basis of clinical need, which means there is no justification for the use of minimum waits
- all organisations must have reviewed planned waiting lists for all specialities and diagnostic services no later than December 2011. Patients should be added to planned waiting lists only if there are personal or clinical reasons
- The Operating Framework stipulates that there is no justification for the use of blanket bans for treatments that do not take account of healthcare needs of individual patients
- clinically led indicators for accident and emergency will remain in place during 2012/13 and information on this is to be published locally. The ability of local commissioners to impose fines will continue. Operational performance will be judged nationally using the current operational standard that 95 per cent of patients are seen within four hours
- SHAs are to complete the roll-out of NHS 111 by April 2013 using solutions such as: Any Qualified Provider (AQP) principles for procurement; establishing services initially through pilots; and an 'opt-in' model involving a consortium of NHS Direct, ambulance services and other providers
- CCGs need to lead the design of urgent care service provision through NHS 111. In any solution reached, there must be evidence of local clinical approval and compliance with national service specifications.
- breaches of mixed-sex sleeping accommodation will continue to attract contract sanctions through the NHS contract.

Domain 5: treating and caring for people in a safe environment and protecting them from avoidable harm

- providers and commissioners need to identify and agree plans for reducing MRSA bloodstream and CDiff infections
- there will be national monitoring for hospital-related venous thrombo-embolism

- PCTs need to ensure a sustained focus on safeguarding to ensure access to the expertise of designated professionals and to work with CCGs to ensure they are prepared
- PCTs need to work with local authorities on the transfer of public health commissioning, and PCT clusters must maintain appropriate investment in public health services throughout transition. The number of four week smoking quitters and NHS healthchecks will be monitored nationally
- accountability arrangements for emergency preparedness, resilience and response should be clear at all times through the transition. PCTs must ensure they maintain current capability and capacity of existing Hazardous Area Response Teams in ambulance trusts.

The Operating Framework highlights examples of good practice to support of the delivery of the QIPP challenge.

REFORM

The new commissioning landscape

- the Operating Framework reiterates that PCTs and SHAs will remain statutory organisations throughout 2012/13. They will be held to account on delivering ongoing performance and supporting development of new organisations and clinical leadership for commissioning
- further guidance will be published in 2012/13 on the transfer of responsibilities from PCTs to the NHS Commissioning Board
- PCTs must support the CCG authorisation processes, development of commissioning support offers, establish effective transition for services and staff, and demonstrate they are allocating both non-pay running costs and staff to support emerging CCGs. They will work with GP practices to review practice registered patient lists by March 2013
- SHAs and PCTs must support shadow health and well-being boards and encourage CCGs to take an active part in their formation
- specific guidance on the CCG authorisation process will be issued, but CCGs should be coterminous with a single health and wellbeing board as far as possible
- by 31 January 2012 SHAs should be confident that any CCG configuration issues can be solved by end of March 2012. SHA clusters are responsible for oversight of the readiness of CCGs for authorisation
- almost half of available budgets have already been delegated to emerging CCGs, and delegation is expected to increase. CCGs will need to:
    - manage budgets well and play active roles in 2012/13 planning
    - develop relationships with local partners including (social care, local community) and be active on the shadow health and wellbeing boards
    - deliver relevant share of QIPP agenda
    - address configuration issues by end of March 2012
    - prepare application for authorisation and identify how to secure commissioning support and plans to use running cost allowance

- commissioning support must be commercially viable and distinctly separate from the PCT cluster and may occupy different geographic service footprint to PCT clusters and their PCT constituents
- it is expected that clinical senates and networks will be established in 2012/13.

The new public health landscape

- Public Health England will operate in shadow form 2012/13 and as a statutory executive agency from April 2013
- the NHS will be accountable for delivering successful public health transition with local authorities. PCT and SHA clusters will need robust transition plans for public health
- PCTs will need to work with local authorities to develop the vision and strategy for the new public health role, prepare local systems for new commissioning arrangements, ensure new clinical governance arrangements are in place and test the new arrangements for emergency planning, resilience and response.

The new provider landscape

- the Operating Framework confirms that NHS trusts are expected to achieve FT status on their own or part of an existing NHS FT or in another organisational form by April 2014
- national support will be considered for a small number of NHS trusts where solutions cannot be found locally
- in 2012/13 PCTs should start to offer patients choice of AQP in at least three services. They should work with CCGs and patients to set outcomes-based specifications for providers to deliver high-quality services.

Choice and personal health budgets

- PCTs need to continue implementing choice of: named consultant team, diagnostic test provider, post-diagnosis treatment, treatment and provider in mental health, care for long-term conditions and maternity care
- from April 2012 providers will accept patients referred to a clinically appropriate named consultant-led team and list their services on Choose and Book
- PCTs are to work with GPs to establish new outer areas to enable patients to stay with their existing practice. Three pilots will take place looking at opening up choice beyond traditional practice boundaries. PCTs will need to ensure patients who register with a practice beyond their local area have an appropriate access to local urgent care services
- PCTs need to prepare for wider roll out of personal health budgets. Subject to programme evaluation this should include offers to all patients with NHS continuing care for relevant aspects of care by April 2014.

Information

- the NHS will need to prepare for the forthcoming information strategy to give patients better access to their records, provide information on outcomes to support choice, support integrated care through sharing of information, and allow for better use of aggregated information

- NHS organisations will ensure availability and quality of key NHS datasets published by Prime Minister David Cameron[1]
- patients written to about the summary care record should have one created by March 2013
- organisations are to use the NHS number consistently in 2012/13 and commissioners should link the use of the NHS number to contractual payments. There will be punitive contract sanctions for any organisations not compliant by 31 March 2013
- appropriate governance policies and guidelines for protecting information must be implemented. This is particularly important during transition.

Workforce

- NHS and partner organisations must sustain a talent pipeline for critical posts. Nationally the new NHS Leadership Academy will provide talent management for all those involved in leadership of healthcare
- the NHS should use the NHS staff survey to improve staff experience and services
- organisations should improve staff health and well-being, including ensuring occupational health services are accredited, following NICE public health guidance, making pledges through the Public Health Responsibility Deal and promoting flu vaccination for staff.

Education and training

- In 2012/13, SHAs remain accountable for education funding, commissioning decisions, medical recruitment and working with healthcare providers. SHAs are to set up provider-led partnerships to take on these responsibilities from April 2013 and work on education commissioning for 2012 to 2014, as well as medical recruitment in 2012
- SHAs need to ensure business continuity and plan for transfer of education and training contracts
- SHAs need to plan for implementation of revised education and training tariffs.

Pension and pay

- The NHS will be required to implement increased employee contributions from April 2012. A pensions charter will clarify roles and responsibilities.
- This is the second year of a two-year pay freeze for public sector workers and the Government recommends that staff earning £21,000 or less receive a flat rate increase of £250 from April 2012.

FINANCE AND BUSINESS RULES

Surplus strategy

- aggregate surpluses for 2011/12 among SHAs and PCTs will continue to be made available to these organisations during the following year. The 'drawdown' of surplus is projected at £150m

[1] http://www.number10.gov.uk/news/letter-to-cabinet-ministers-on-transparency-and-open-data/

- no PCT or SHA should be planning for an operational deficit in 2012/13 and PCTs carrying a legacy debt will be required to clear it. CCGs will not be responsible for PCT legacy debt arising prior to 2011/12 and are expected to work closely with PCTs and clusters to ensure no PCT ends 2012/13 in deficit. NHS trusts must plan for a surplus consistent with their pipeline plan and their tripartite formal agreement (TFA)
- PCTs will continue to set aside 2 per cent of recurrent funding for non-recurrent spending. SHAs will hold these funds, with PCTs required to submit business cases to access them. The non-recurrent cost of organisational and system change will need to be met from the 2 per cent.

PCT allocations

- PCT recurrent allocations will grow by at least 2.5 per cent. PCT 2012/13 revenue allocations will be announced in December 2011 and will be informed by the Office for Budget Responsibility's inflation forecast. Additional allocations for primary dental services, general ophthalmic services and pharmaceutical services will also be announced in December 2011
- transfers of funding between PCTs and local authorities included in the NHS Operating Framework 2011/12 will continue, including £622 million in 2012/13 for social care services to benefit health
- financial support from the health system for social care will continue in 2013/14 and 2014/15.

Running costs

- targets for running cost savings will be set at SHA cluster level, with the assumption that there will be no further savings at the SHA organisation level during 2012/13
- the running cost allowance for CCGs from 2013/14 is expected to be £25 per head of population per annum before any entitlement to a quality premium
- the running cost allowance for the core functions of the NHS Commissioning Board will be at least £492 million.

Capital

- NHS trusts must ensure they have a clean and safe environment by prioritising any urgent backlog maintenance and upgrading work. They should also evaluate the need for any single en-suite rooms that may be required to fulfil their obligations regarding mixed sex accommodation, patients' dignity and infection control
- capital expenditure plans for NHS trusts and PCTs will be agreed by SHA clusters. Any unspent capital allocation will not be carried forward.

Tariff

- the development of the national tariff for 2012/13 is driven by increasing the quality of care and outcomes, driving integration of services and incentivising delivery of QIPP
- the scope of the tariff will be extended to: require the recently developed currency to be used when contracting for adult mental health services; introduce mandatory currencies for chemotherapy delivery, external beam

radiotherapy and ambulance services; introduce non-mandatory currencies for HIV outpatient services and some community podiatry; introduce a 'quality increment' for patients at regional major trauma centres, to facilitate the move to trauma care being provided in designated centres; introduce national 'pathway' tariffs for maternity care, cystic fibrosis and paediatric diabetes; and introduce tariffs for post discharge care for some procedures, which will be mandatory where acute and community services are integrated in one trust

- best practice tariffs will be expanded to: incentivise more procedures being performed in a less acute setting and same-day emergency treatments where clinically appropriate; increase the payment differential between standard and best practice care for fragility hip fracture care and stroke; and promote the use of interventional radiology procedures
- the 30 per cent marginal rate will continue to apply for increases in the value of emergency admissions, as will the policy of non-payment for emergency admissions. The DH is working with the Foundation Trust Network to produce more detailed guidance on the operation of this policy in 2012/13
- commissioners will be required to adjust the tariff price if the type of patients that a provider treats results in it incurring lower costs than the average of the tariff category. This is intended to respond to concerns about 'cherry picking'
- the national efficiency requirement for 2012/13 is set at 4 per cent, which will be offset by pay and price inflation. The tariff price adjuster will be a reduction of at least 1.5 per cent and will also be applied to non-tariff services. This will be confirmed in the 2012/13 Payment by Results guidance following allocations
- some best practice tariffs have a built in efficiency assumption, allowed for in the overall tariff price adjusted. Others will lead to reduced payments where best practice is not achieved and this is not allowed for in the tariff price adjuster
- for 2012/13 the DH will continue to work on existing long term condition tariffs to support the development of higher-quality primary and community-based services.

CQUIN framework

- CQUIN will be developed in 2012/13 so that for all standard contracts, the amount providers can earn will be increased to 2.5 per cent
- national goals on venous thrombo-embolism (VTE) risk assessment and on responsiveness to personal needs of patients will continue alongside two new national goals: improving diagnosis of dementia in hospitals and increasing using of the NHS Safety Thermometer
- where CQUIN funding has been used to achieve higher quality, funding may be made recurrent only when the commissioner is satisfied it is necessary to maintain any improvement
- commissioners and providers should refer to the NHS Chief Executive's Innovation Review (due in December 2011) when developing CQUIN schemes for 2012/13.

Clinical audits

- work is underway to transfer the cost of established clinical audits within the National Clinical Audit and Patient Outcomes Programme (NCAPOP) to providers of relevant and tariffed services from 2012/13.

SHA bundle

- the proposed value of the SHA bundle of funding is £6.4bn, the same amount as in 2011/12. Further detail will be released with financial planning guidance. Clinical networks will continue to be funded through the SHA bundle in 2012/13.

Joint working with local authorities

- PCT clusters will need to work with local authorities to jointly agree priorities around investment of funds allocated for reablement in 2012/13. This could include funding new services such as the social care aspects of the national dementia strategy and impact actively on delayed transfers of care
- PCT clusters will need to continue to transfer social care funding within allocations to local authorities to invest in social care services.

Procurement

- the DH is preparing a procurement strategy to be launched by April 2012 to help trusts improve their procurement performance. Trusts that spend more on goods and services than the benchmark will have to justify why they are doing so.

Contract management arrangements

- the 2012/13 NHS Standard Contract will be a single agreement for use by commissioners when commissioning services from providers seeking to deliver NHS-funded secondary and community services. Contracts will be limited to 12 months for 2012/13
- work will continue on the transfer of clinical contracts from current commissioners to the new commissioning authorities. Guidance on the later stages of the transfer process will be issued during 2012.

Principles and rules for cooperation and competition (PRCC)

- PCT clusters must review their practices in line with the Cooperation and Competition Panel's report on the operation of AQP in elective care to ensure they are compliant with the PRCC. Any decisions restricting patient choice must be taken at board level and published annually with the associated rationale, impact and period of operations. SHA clusters will have oversight of the PRCC locally in 2012/13.

PLANNING AND ACCOUNTABILITY

- in 2012/13 SHAs will continue to work through SHA clusters to hold PCT clusters to account. From 2013/14, the NHS Commissioning Board will be held

to account by the DH, and commissioners should anticipate a more outcomes-based approach
- each PCT cluster is required to have an integrated plan for the period 2012/13 to 2014/15, building on previous plans. Integrated plans should have a clear focus on quality and the national priorities set out in the Operating Framework. Technical planning guidance will be published in December 2011, setting out key milestones and financial planning guidance is due to be published in January 2012
- at a minimum, PCT clusters must ensure that CCGs explicitly support plans for 2012/13 and beyond to ensure a strong base on which to build their own planning from 2013/14. Plans should reflect the outcomes of local Joint Strategic Needs Assessments and the public health transition elements should be supported by local authorities.

Performance monitoring and assessment

- three groups of indicators will be used to nationally assess the performance of PCT and SHA clusters: quality (covering safety, effectiveness and experience); resources (covering finance, workforce, capacity and activity); and reform (covering commissioning, provision and patient empowerment)
- PCT clusters will also be monitored against the key milestones for the transformational change elements of QIPP and reform, agreed with SHA clusters as part of the planning round.

ROTHERHAM BOROUGH COUNCIL – HWBB

1.0	**Meeting:**	**Health & Wellbeing Board**
2.0	**Date:**	**18th January 2012**
3.0	**Title:**	**Health & Wellbeing Board Work Programme and the HWB Support and Development Plan**
4.0	**Directorate:**	**Neighbourhoods and Adult Services**

5.0 Summary

This report sets out the draft work programme for the Health and Wellbeing Board (HWBB) for the first year of operation. This has been developed to address the challenges set out by the network of early implementers of HWBs, which is being led by John Wilderspin of the Department of Health, which has identified a number of challenges which boards are facing.

This work programme is underpinned by a support and development plan which uses the Good Governance Institutes Board Assurance Prompt toolkit to becoming and exemplar board by December 2012.

6.0 Recommendations

- **That the HWBB approve the work programme and the HWBB support and development plan.**

7.0 Background

Health and Wellbeing Boards provide the potential to deliver transformational change in health and social care outcomes. To realise this potential they need to be built on firm foundations of trusting relationships, agreed priorities, a focus on outcomes, a shared vision and agreement about what success will look like.

There is a desire for Health and Wellbeing Boards (HWBBs) to really make a difference. Boards provide an opportunity to do things differently. In order to achieve this, the HWBB needs to:-

- Be clear about shared purpose and priorities.
- Develop a shared leadership approach which fosters mutuality.
- Regularly review progress against agreed goals and outcomes.

The HWB offers an opportunity for system-wide leadership to improve both health outcomes and health and care services. The HWB has a duty to promote integrated working and drive improvements in health and wellbeing by promoting joint commissioning and integrated delivery. An effective board will bring together senior leaders in Rotherham to build a commitment for transformational change.

In order for the Board to structure its work and resources to achieve an improvement in health inequalities and drive the transformational change that is needed to meet the demographic and financial challenge, it will need to have a coherent framework to guide and assure it's development.

The network of early implementers of HWBBs, which is being led by John Wilderspin of the DH, has identified a number of challenges which boards are facing:-

- Membership – commissioners, providers, voluntary sector?
- Developing relationships between the HWBB and Council overview and scrutiny.
- The need to understand the constitutional issues of taking on new functions and the potential conflicts of interest that may arise ie the HWB role in contributing to the NHS commissioning Board's annual assessment of CCGs.
- Concerns about Healthwatch's ability to contribute at a strategic level.
- The formal role of senior council officers as members alongside elected members.
- The tension between taking a high level strategic role or being more actively involved in joint commissioning.
- The links to wider partnerships such as the LSP.
- How much of the children's agenda will the board cover?

- Safeguarding – can boards ensure that safeguarding of children and vulnerable adults is seen as everybody's responsibility?

At the heart of the modernisation programme is an ambition to deliver world class outcomes, an ambition which applies equally to healthcare, public health and social care outcomes. To support the implementation of this ambition there are now three strategic outcome frameworks, NHS outcome framework, Public Health Outcomes and Adult Social Care outcomes.

The purpose of the three frameworks is to ensure focused accountability (not blurring lines of responsibility) while recognising the different delivery models. The refreshed NHS Framework published in December 2011 included areas where there would be shared indicators between the three frameworks, emphasising the importance of alignment and encouraging collaboration and integrations.

8.0 Proposals and Details

To address the series of challenges, opportunities and development issues that can be anticipated the attached work programme has been drafted.

The work programme (appendix 1) sets out the key actions that need to be delivered in the first 12 months of the board. The first year of the board will be focused on ensuring that it is fit for purpose and can deliver its core functions:

- Assess the needs of the population through the Joint Strategic Needs Assessment (JSNA)
- Agree and produce a Health and Wellbeing Strategy to address needs, which commissioners will need to have regard of in developing commissioning plans for health care, social care and public health.
- Promote joint commissioning
- Promote integrated provision, joining up social care, public health and NHS services with wider local authority services
- Involvement in the development of CCG commissioning plans
- Provide advice to the NHS Commissioning Board in authorising CCG's

Underpinning the key actions is a plan to support the development and improvement of the board. This has been developed using the Good Governance Institute's Board Assurance Prompt self assessment toolkit. The toolkit sets out a path from basic level to becoming an exemplar HWBB where others learn from our consistent achievement in six key elements:

- Purpose and vision
- Strategy
- Leadership of the local healthcare economy
- Governance
- Information and Intelligence
- Expertise and skills

The colour coded plan sets out how on a quarterly basis the board can move up each progress level to becoming an exemplar by the end of December

2012. A series of actions are identified in each quarter which will need to be tasked to accountable lead managers to be delivered and outcomes reported through to the Board. This plan will also help to forward plan and set future HWBB agenda's. Performance Management of this plan will be done through the HWBB support structure.

9.0 Finance

There are no financial implications associated with the development of the work programme and support and development plan.

10.0 Risks and Uncertainties

Failure to implement this work programme will impact on the ability to put in place effective board arrangements within the timescales set out by the Department of Health. It will impact on the governance of the board and the board for fit for purpose to achieve the core functions and outcomes set out by the Department of Health.

11.0 Background Papers and Consultation

Good Governance Institute Board Assurance Prompt for Health and Wellbeing Boards

Contact Name: Shona McFarlane, Director Health and Wellbeing
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Overarching cross-cutting 'impact' performance measures

Domain	Proposed measure
Improving population health and talking health inequalities	• Differences in how long the best and worst off people can expect to live/to live without major health problems • Babies born at a healthy birth weight
Preventing people from dying prematurely	• Potential years of life lost from causes amendable to healthcare • Deaths from avoidable diseases
Enhancing quality of life for people with long term conditions	• Quality of life for people with long-term conditions • Quality of life for people in social care
Preventing deterioration and helping people to recover from episodes of ill-health or following injury	• Hospital admission for things that should usually be treatable outside hospital • The proportion of people leaving hospital who end up back in hospital within 28 days
Ensuring people have a positive experience of care	• Peoples experience of GP services • Peoples experience of being in hospital • Satisfaction with social care services
Treating and caring for people in a safe environment and protecting them from avoidable harm	• The number of safety incidents reported by hospitals and the number of incidents that leave to serious harm

Rotherham Health and Wellbeing Board

Work Programme - Year 1 (October 2011 – September 2012)

No.	Key Action	Lead Agency / Lead Officer	Completion Date	Excellence Plan Ref.
1	Agree Terms of Reference, Roles and Responsibility of the Board		Complete December 2011	1.1, 1.2, 1.3, 1.4, 4.1 and 6.1
2	Hold a Health Summit to define priorities for all stakeholders		Complete December 2011	1.5
3	Undertake a review of HWBB pilots and feed learning into Board work programme and improvement plan		February 2012	4.2
4	Agree the Joint Strategic Needs Assessment		January 2012	2.3
5	Agree HWBB Priorities across all stakeholders		February 2012	1.2, 1.3, 1.5, 1.6 and 2.4
6	Put in place a Joint Commissioning Model		March 2012	2.5
7	Develop a Performance Management Framework based on the outcomes framework and the priorities of the board		April 2012	5.1, 5.2 and 5.3
8	Publish Rotherham's Health and Wellbeing Strategy		April 2012	1,8, 2.1, 2.2, 2.4 and 2.6
9	Complete a review of health complaints ahead of the transition		June 2012	5.5
10	Develop effective HealthWatch arrangements in Rotherham		September 2012	4.7

Rotherham Health and Wellbeing Board - Board Development Excellence Plan				
Basic Level Oct 11 – Dec 11	**Early Progress Jan 12 – Mar 12**	**Results Apr 12 – June 12**	**Maturity Jul 12 – Sept 12**	**Exemplar Oct 11 – Dec 12**

1. PURPOSE AND VISION

No.	Key Action	Who?	Timeline
1	Agree purpose of the Board	complete	October 11
2.	Publish values and board priorities to public and in key stakeholder documents		November 11
3.	Ensure all HWBB members understand the boards role		December 11
4.	Hold a Health Summit to identify priorities with all stakeholders.		December 11
5.	Agree values, board priorities and work programme		January 2012
6.	Agree priorities and stretch goals with all stakeholders		January 12
7.	Agree ethical values combined with a robust mechanism for adding and removing services and/or care settings against these		March 12
8.	Ensure all plans are rooted in local population needs		April 12
9.	Undertake public engagement and public accountability testing on purpose and vision		June 12
10.	Ensure the work of relevant existing local partnership groups eg. The Local Strategic Partnership has been considered		June 12
11.	Hold an annual HWBB debate on organisational purpose, and how in-year achievements or issues impact on this.		August 12
12.	Ensure we systematically match how purpose dovetails with population needs		September 12
13.	Demonstrate we are achieving our purpose and vision as we are benefiting population health in accordance with our plans		December 12
14.	Influence both local health and local authority commissioners		December 12

2. STRATEGY			
No.	**Key Action**	**Who?**	**Timeline**
1	Undertake a review of all relevant strategies		January 2012
2	Set out a timetable for developing HWB Strategy		February 2012
3	Agree the Joint Strategic Needs Assessment and make sure the JSNA is the base for all strategic decisions		February 2012
4.	Ensure the HWBB Strategy is underway		February 12
5.	Put in place a joint commissioning model and an agreement is in place for areas of joint commissioning.		March 12
6.	Publish the HWB Strategy, which includes improvement milestones and how these will be measured		April 12
7.	Put in place a framework for ensuring the HWBB strategy has been reviewed and refined in the light of successful achievement of milestones, and new intelligence and aspirations		September 12
8.	The HWBB strategy has benefited other healthcare economies to our own, as well as influencing the strategic direction of all local partner organisation		December 12

3. LEADERSHIP OF THE LOCAL HEALTHCARE ECONOMY			
No.	**Key Action**	**Who?**	**Timeline**
1	**Communicate the leadership of the HWBB and their contact details to key stakeholders**		**January 2012**
2	**Identify relevant stakeholders and invite to participate**		**January 2012**
3	**Make sure that local health and social care resources are understood**		**January 2012**
4.	**Make sure Leadership development for HWBB discussed and agreed and development plans initiated**		**February 12**
5.	**All stakeholders understand leadership issues for HWBB**		**February 12**
6.	**Relevant stakeholders regularly attend and provide input into work programme**		**March 12**
7.	**Results of partnership working systematically reviewed by HWBB.**		**April 12**
8.	**Evidence that relationships with CCG's are positive and there is ongoing dialogue about commissioning and contracting decisions**		**June 12**
9.	**Public health voice is evident in commissioning and contracting decisions**		**June 12**
10.	**Review success of leadership approach.**		**July 12**
11.	**Make sure ongoing succession plans are in place**		**September 12**
12.	**Demonstrate benefits of partnership working have enabled the majority of stakeholders to meet their improvement trajectories and resource allocation**		**September 12**
13.	**Demonstrate benefits of partnership working have enabled the majority of stakeholders to exceed their improvement trajectories.**		**December 12**
14,	**Outcomes have been improved and this is traceable back to initiatives from the HWBB**		**December 12**

4. GOVERNANCE			
No.	**Key Action**	**Who?**	**Timeline**
1	**Membership and terms of reference for the HWBB have been drafted, shared and are fully agreed**	Complete	**December 11**
2	**Examine the work of the pilot HWBB's to inform how we work**		**January 2012**
3	**The HWBB has been fully set up and first annual cycle of business agreed.**		**January 12**
4.	**Develop relationships with relevant local organisations**		**March 12**
5.	**Local stakeholders have clearly incorporated HWBB accountabilities into their own governance arrangements.**		**June 12**
6.	**Carry out a structured annual review of the HWBB and make improvements to structure and organisation**		**September 12**
7.	**Develop effective HealthWatch arrangements in Rotherham and make sure that they are embedded into the HWBB governance.**		**September 12**
8.	**Good governance benefits to HWBB identified and we know how our better governance practice has influenced local partner organisation.**		**December 12**

5. INFORMATION AND INTELLIGENCE			
No.	**Key Action**	**Who?**	**Timeline**
1	**Identify information requirements and agree format for initial performance management framework.**		**January 2012**
2	**A dashboard of key information and performance management framework has been developed based on the outcomes framework and priorities and discussions on how to improve our information are underway.**		**March 12**
3	**KPI's reflect shared performance objectives across health and social care**		**April 12**
4.	**The HWBB has current published strategy, which includes improvement milestones and how these will be measured**		**April 12**
5,	**Complete a review of health complaints to ensure that customer experience is captured and feeds into the HWBB**		**June 12**
6.	**HWBB informed by real-time intelligence, demonstrating improved outcomes, quality and efficiency across health and social care**		**September 12**
7.	**Outcomes and performance benchmark against the best performers**		**December 12**

6. EXPERTISE AND SKILLS			
No.	**Key Action**	**Who?**	**Timeline**
1	**Skills and expertise for HWBB members have been indentified and agreed**		**February 2012**
2	**Induction and development plans for the HWBB are up and running**		**March 12**
3	**HWBB influencing skills are evident by success in positive change to local contracts and the pattern of local provision.**		**June 12**
4.	**The HWBB supports CCG's and local authority by valuing key commissioning skills.**		**September 12**
5.	**The HWBB acts as a forum to bring specialist skills and expertise to support commissioning e.g. clinical advice from local providers**		**September 12**
6.	**The HWBB is influencing the organisation development of partner organisations.**		**December 12**
7.	**The local health and social care economy is recognised as being a good career choice for commissioning professionals.**		**December 12**

Overarching cross-cutting 'impact' performance measures

Domain	Proposed measure
Improving population health and tackling health inequalities	▪ Differences in how long the best and worst off people can expect to live/to live without major health problems ▪ Babies born at a healthy birth weight
Preventing people from dying prematurely	▪ Deaths that might have been avoided by better treatment ▪ Deaths from avoidable diseases
Enhancing quality of life for people with care needs	▪ Quality of life for people with long-term conditions ▪ Quality of life for people in social care
Preventing deterioration and helping people to recover from episodes of ill-health or following injury	▪ Hospital admission for things that should usually be treatable outside hospital ▪ The proportion of people leaving hospital who end up back in hospital within 28 days
Ensuring people have a positive experience of care	▪ Peoples experience of GP services ▪ Peoples experience of being in hospital ▪ Satisfaction with social care services
Treating and caring for people in a safe environment and protecting them from harm	▪ The number of safety incidents reported by hospitals and the number of incidents that lead to serious harm.

ROTHERHAM BOROUGH COUNCIL – HEALTH & WELLBEING BOARD

1	**Meeting:**	**Health & Wellbeing Board**
2	**Date:**	**18th January, 2012**
3	**Title:**	**Early Implementer National Learning Sets**
4	**Programme Area:**	**Neighbourhoods and Adult Services**

5 Summary

Health and Wellbeing Boards can be seen as one of series of strategic partnerships that already exist within local areas. HWB' s however are receiving a considerable amount of interest, and are being seen as new arrangements with new opportunities , as part of a dynamic movement for change with the aim of improving outcomes in health, care and wellbeing. Research has shown that all partners are viewing HWB's with enthusiasm, and opportunities for learning more about each partners' area of expertise and resulting gains in health and wellbeing, and reducing health inequalities that can be gained are being welcomed. HWB's are seen as offering the opportunity for system wide leadership to improve both health outcomes and health and care services through integrated working. To support this level of interest in these new partnerships, the government has invested heavily in their development. One of these methods is the Accelerated Learning Sets programme.

The programme of Accelerated Learning Sets was launched in November 2011 to help emerging health and wellbeing boards to work together on the biggest challenges that face them on their way to statutory running from April 2013. More than 90 out of 152 emerging health and wellbeing boards from across England are represented in the 11 learning sets. The sets are focused on themes that early implementers have said are of most interest and importance to health and wellbeing board members. They include:

- improving the health of the population (2 sets)
- bringing collaborative leadership to major service reconfiguration (2 sets)
- creating effective governance arrangements
- how do we 'hard wire' public engagement into the work of the board
- raising the bar on JSNA's and Joint health and wellbeing strategies
- improving services through more effective joint working
- making the best of collective resources.

Each learning set includes members from local government and NHS organisations, with a nominated lead, policy lead and appointed facilitator. The lead facilitators are recruited through the NHS institute which is leading on this

process, and the sets are supported by Policy Leads from the Department of Health. The peer-to-peer learning approach encourages senior people to share solutions that are already working, shape new solutions and influence national policy makers in the areas that matter to emerging boards and their constituent members.

The learning sets will play a crucial role in bringing together leaders from across the NHS, local government and new clinical commissioning groups. Through collaborating, learning and sharing together, these learning sets have the potential to create a powerful movement of integrated services that deliver better outcomes for local people.

Rotherham

Rotherham is represented on the learning sets by Shona McFarlane, Director of Health and Wellbeing who is a Set Lead for the "Bringing collaborative leadership to major service reconfiguration learning set". This was a popular set and there was competition for entry; a second set was established due to the level of interest. The learning sets were launched and held their first meetings in London on 15 November 2011.

The Leading Change set comprises members of other Shadow Health and Wellbeing Boards from across the Country, including elected members, Director of Public Health, Chief Executives and senior commissioning managers. The set has met 'virtually' once and will meet in this way a further twice, up to February using technology such as web conferencing. A face to face meeting will be held in February and the set will publish the outputs of its work in March 2012.

The Leading Change set is in the process of finalising its terms of reference but the main area it will consider is how the newly formed HWB's will work together to achieve significant system change. The learning set will examine how Health and Wellbeing Boards can achieve more rapid progress in this regard by leveraging the commissioning partnership and expertise across agencies.

Outputs from all sets will be published in March but the Communities of Practice website is providing a virtual engagement mechanism in the meantime.

The launch of the learning sets is just one of several components of the national development plan for Health and Wellbeing Boards. Other elements include the communities of practice on-line portal and a leadership development programme for elected members, which is due to be rolled out shortly and which will be delivered by the LG Group. In addition there is specific guidance available on JSNA's and Health and wellbeing strategies. Regular reports and learning from the sets will be shared with the HWB.

Resource Implications

The commitment required by the national learning set will be met through existing resources.

Recommendation

- **The Health and Wellbeing Board is recommended to note the contents of this report.**

- **Members are encouraged to join the DoH Communities of Practice website for further information, dialogue and debate.**

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